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BUSINESS, LABOR, AND CONSUMERS: VIEWS ON HEALTH CARE AND LONG-TERM CARE

HEARING

BEFORE

THE PEPPER COMMISSION

U.S. BIPARTISAN COMMISSION
ON
COMPREHENSIVE HEALTH CARE

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

CINCINNATI, OH

JULY 5, 1989

PART 3

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BUSINESS, LABOR, AND CONSUMERS: VIEWS ON HEALTH CARE AND LONG-TERM CARE

WEDNESDAY, JULY 5, 1989

THE PEPPER COMMISSION
U.S. BIPARTISAN COMMISSION ON
COMPREHENSIVE HEALTH CARE
Cincinnati, OH.

The Commission met, pursuant to notice, at 9:30 a.m., in Lindner Hall, College of Business Administration, University of Cincinnati, Hon. Bill Gradison (Vice Chairman of the Commission), presiding.

Present: Representative Bill Gradison, Commissioner James Balog, and Commissioner James Davis.

Also Present: Edward F. Howard, general counsel; Steven C. Edelstein, Philip Shandler, and Joy Johnson Wilson, professional staff.

OPENING STATEMENT OF CHAIRMAN BILL GRADISON

Chairman GRADISON. Ladies and gentlemen, I'm Bill Gradison, appearing in my capacity as vice chairman of what we affectionately call the Pepper Commission, and known originally as the U.S. Bipartisan Commission on Comprehensive Health Care.

This Commission was created last year and charged by the Congress to come in with recommendations with regard to appropriate legislative action to deal with the very serious problems of long-term care and health care of the uninsured. The Commission is made up of 15 members, 6 from the Senate, 6 from the House, and 3 appointed by the President.

Today's hearing is the third of a series of hearings being held around the country, gathering recommendations and facts that we can take into account in framing our recommendations, working against a target of a report in November of this year.

There will be another hearing in Ohio tomorrow in Cleveland, the fourth of the series of hearings.

I'm happy to be joined today by two of the Presidential appointees to this Commission. On my right, Jim Balog, and on my left, Dr. Jim Davis.

At this point, before beginning the hearing, I would like to turn to my colleagues, my fellow Commissioners, for any opening comments that they may wish to make.

OPENING STATEMENT OF COMMISSIONER JAMES BALOG

Commissioner BALOG. Good morning everybody, and thank you, Congressman Gradison. I want to thank the attendees in advance

for the help that I know you will render to us in these important deliberations.

Testimony, such as we are going to get here today, is very useful in trying to understand the breadth and the complexity of the health care problems in America.

I've participated in hearings like this for a number of hours over the past few years, and always come away with the notion that what we are looking at in the health care system is, indeed, a very complex matter.

The health care system is a closed system, it's like a balloon. You squeeze it in one place, something pops out somewhere else. Whatever we do in the government policy area by squeezing one place something else comes out someplace else.

In addition to the fact that it's a closed system, where somebody gets and somebody gives, we have the question of allocating resources. There are many things that all of us would like to have done, but we have to decide what we can do now with whatever resources we have. So, it's a question of allocation that comes into play here, and all of these allocations affect us in every day of our lives whatever choices we may make in allocations.

And, as Congressman Gradison mentioned, our immediate concern is long-term care and comprehensive care for some 37 million Americans who are not now adequately covered by various private and governmental plans.

Just these two alone have the potential, in dollars, to double the size of the medical care programs funded through taxation and sponsored by the Federal Government. So, these two issues alone, if we talk about allocation of resources, are very big, indeed, all by themselves, without considering all the many other aspects of our health care system that need some kind of redress over the coming years.

So, I'm going to look forward to hearing your views. I also would point out that whatever questions I have, and I suspect my colleagues as well, are questions designed to elicit information. It doesn't necessarily mean that I believe this or that at this stage. Part of why we are here is to get information so that after many, many months of deliberation and hearing other people, we'll form those conclusions. But, at the moment, questions are designed so that I can learn as much as possible from whatever you have to contribute to the meeting, and I'm sure it will be a lot.

Thank you very much for your help.

Chairman GRADISON. Dr. Davis?

OPENING STATEMENT OF COMMISSIONER JAMES DAVIS

Commissioner DAVIS. Thank you, Congressman Gradison. Let me say how happy I am to be here this morning, and how very pleased the physicians of this country, and, particularly, the American Medical Association is, in having a representative on this Bipartisan Commission on Comprehensive Health Care. And, I hope this Commission will take the word comprehensive seriously and we will look at the uninsured, certainly we look at long-term care, but I hope that we will also look at some of the other problems that we have in our system.

The physicians of this country are violently opposed to rationing health care in this country. We have, literally, the best system that mankind has yet devised. It needs change, and you are aware of the polls that show that over 80 percent of our people say yes, we need to change our health care system, and I was a little bit surprised that that wasn't a higher figure. If they had asked me, I would certainly have said, yes, this system does need to be changed. It does not need to be thrown out and some other type of system imported into this country. We can work at changing many of the aspects, the Medicare Program, the uninsured, the problems of the adolescents, to mention a few. Long-term care is an issue that this country has got to come to grips with.

We can work with these in a constructive, cooperative way and improve the best health care system in the world, not to throw it out. We do not want to see health care in this country rationed. That has been the difference between our system and most of the others in the world, in that we have always tried to have access to affordable quality care for every single citizen. We have not yet succeeded in that. Working together, I am confident that we can succeed in accomplishing that.

We welcome your participation today. I thank you very much for being with us. We look forward to your testimony.

Thank you, sir.

Chairman GRADISON. Thank you. Thank you both.

One general comment I'd like to make about the process we'll be following. We have a list of witnesses who will be heard today. We would welcome written comments from those who wish to share their thoughts with us but who are not included on the witness list today, and we certainly assure you that any comments that are received will be reviewed carefully by all of the members of the Commission, as well as by our staff.

Our first scheduled witness is William Reina, associate manager of personnel administration for the Procter & Gamble Co. Mr. Reina? Could you identify those who are with you, too, as part of your statement please, sir?

Mr. CARROLL. I'll do the identification.

Chairman GRADISON. Thank you.

STATEMENT OF CHARLES CARROLL, VICE PRESIDENT, PROCTER & GAMBLE CO.

Mr. CARROLL. I'm Charlie Carroll. I'm the vice president of the Procter & Gamble Co. With me today is Bill Reina, associate manager of personnel administration, Procter & Gamble; John Lucia, consultant, employee benefits and policies; and Mr. James Bell, manager, corporate health care benefits. They are knowledgeable about Procter & Gamble's health plans in general and the structuring particulars of our long-term care plan. Mr. Reina will be our chief spokesman.

If I may, I'd like to take a moment and provide a little background on Procter & Gamble. It was founded in this city in 1837, and in the past 150 years it has become one of the world's major consumer products companies, with over $20 billion in annual sales in the 1988–89 fiscal year.

The company markets more than 100 different brands, in detergent, paper, food, beverage, and health care areas. P&G operates in all 50 States, as well as in over 100 countries throughout the world. It employs 45,000 people domestically, and another 33,000 in its international subsidiaries. About two-thirds of P&G's business is done within the United States, and the other third, of course, is done internationally.

On behalf of Procter & Gamble, we appreciate the opportunity to testify before the committee this morning on the role of business as it relates to needs of the uninsured and the issue of long-term health care.

Both of these topics relate to such matters as quality health care, long-term care, access to care, retiree health care, catastrophic care, and general cost issues, which are currently being addressed by providers, employers, individuals, and the Nation.

It is important to state that Procter & Gamble believes these four problems are interrelated and require solutions that address all areas in a way that does not merely ask employers, who are already providing superior health benefits to their employees, to pay more of the bill. Doing this would force American businesses to carry in their product prices the cost of expanded medical benefits while simultaneously fighting for competitive survival in world markets.

As a business enterprise, we strongly believe in the value of the employer providing for the welfare of its people. We believe that the interests of the company and those of its employees are inseparable.

Now I'd like to ask Mr. Reina if he will please provide some of the details of our plans.

STATEMENT OF WILLIAM REINA, ASSOCIATE MANAGER, PERSONNEL ADMINISTRATION, PROCTER & GAMBLE CO.

Mr. REINA. In the fall of 1981, we were one of the first national employers to introduce a cafeteria benefits program. As the needs of our employees become more diverse, it is extremely important that Procter & Gamble can find ways of delivering benefits to accommodate individual circumstances and preferences.

We are not advocates of the "one size fits all" philosophy. We have found our cafeteria benefits program to be a very effective way of providing employee benefits that meet their individual needs.

In the fall of 1987, we offered long-term care to our employees, parents of our employees, and our retirees, because we felt it addressed an economic need and a societal problem.

We think that these types of changes are best done in the private sector, but would agree that both public and private sector must cooperate to ensure that all Americans are provided adequate health care.

For the majority of Americans, the delivery of health care coverage is a current reality that is taken for granted. Almost all individuals over the age of 65 enjoy a strong basic coverage through Medicare. Of the individuals under age 65 with coverage, the vast majority derive their coverage from employer-sponsored plans. It is

clear that overall the private sector has responded well to the challenge of meeting the health care needs of those who are employment connected. This is the proper base on which to build, by extending coverage to the 25 million people who have an employment connection but who do not have coverage.

Researchers estimate that about 37 million Americans do not have public or private health care coverage. As mentioned, about two-thirds of these individuals have an employment connection. About 2 million are uninsurable due to medical impairments; the remainder, 10 million, do not have an employment connection.

Because these population groups present separate problems, it is appropriate that specifically determined initiatives be developed for each group.

Insurable individuals with an employment connection. Of our Nation's approximately 135 million employed persons and dependents, 80 percent are covered by employer-sponsored health care plans. The remaining 20 percent account for two-thirds of the total uninsured population, 25 million out of 37 million people.

Emphasis should be placed on attempting to find private sector solutions to covering individuals within this group, rather than creating new government programs, either to mandate coverage or provide care. Employers have successfully provided coverage to the majority of working Americans and their families already.

The knowledge and systems to deliver these benefits are largely in place. Where this isn't available, the government can help employers put in place, but they should not try to take on this job itself, since that could result in a potentially costly, slow, and inefficient solution.

Examples of how the government can help include: (1) Exploring the question of whether favorable group insurance mechanisms could be further extended to small employer groups; (2) providing for the tax deductibility of health care insurance premiums in those cases where self-employed individuals themselves directly purchase health insurance policies; (3) providing special tax incentives, perhaps, limited tax credits, for small and low wage employers; (4) providing assurance that the ERISA preemption principle is not eroded. This is critical. Without it, there will be complexities and added costs for many employers which would work against extending health care to more people.

The advantages of our increasingly market-driven health care system should be retained, and the benefits of the emerging potentially more efficient managed care systems should be considered in developing recommendations to provide insurance for employed individuals not presently covered.

Insurable individuals without employment connection. For those individuals in this category who can afford to purchase health insurance policies directly, incentives along the lines discussed in the preceding category would be appropriate. However, many people in this category may not be able to afford purchasing health insurance coverage. The problem of providing health benefit coverage for the unemployed should not be considered solely an employer-related problem. It is a problem of society.

For the truly poor, public action through the Medicaid Program is already available. This was recently done with respect to extend-

ing coverage to additional young children and pregnant women. Perhaps, consideration should be given to extending Medicaid at a reasonable rate to those who are economically disadvantaged but do not qualify for coverage under current criteria.

Uninsurable individuals. It has been estimated that there are upward of 2 million people in America who are not covered by employer-sponsored health benefit plans and are unable to purchase individual health insurance policies because they have health impairments.

Procter & Gamble does not believe that employers exclusively should be required to finance risk pools for uninsurables. Employers are already providing about $127 billion of coverage for individuals. Providing health insurance coverage to individuals who are unable to obtain insurance in the open market is a societal problem and, thus, it appears that more appropriate to finance pools through general State or Federal revenues, or an expansion of the Medicaid Program.

Position on long-term care. Consistent with previous testimony, Procter & Gamble believes that the issue of providing long-term care should be pursued primarily through the private sector, rather than from Government programs. This is the most effective approach to delivering services and controlling costs. The role of Government programs should be limited to addressing the needs of individuals who cannot afford to pay for long-term care.

For most people, long-term care insurance protects their financial resources. It prevents long-term care expenses from depleting their assets. A major social program that protects the estates of people who could otherwise insure themselves seems questionable.

Procter & Gamble introduced a long-term care insurance plan to active employees in the fall of 1987. By making this benefit available, the company has provided employees a way to insure against the potential significant financial burden of long-term care needs for themselves, their spouses, and their parents. The plan design details of P&G's long-term care program will be provided to members of the committee at the conclusion of this testimony.

Mr. Chairman, members of the committee, we appreciate having had the opportunity to speak to you today, to present Procter & Gamble's position on issues that are important and complex. We hope that our testimony has adequately conveyed the message that Procter & Gamble is committed to quality health care coverage for its own employees, and that we want other employers, if necessary with the aid of incentives, to be in a position to do the same. This alone will address a large part of the current and projected problem.

In terms of the unemployed and uninsured, we, like most other good employers, believe the solution must be a societal response to a societal need.

That concludes my comments.

[The prepared statement of Mr. Reina follows:]

July 5, 1989

WRITTEN

TESTIMONY

U. S. BIPARTISAN COMMISSION

ON COMPREHENSIVE HEALTH CARE

Mr. Chairman, members of the Committee, my name is William Reina. I am the Associate Manager of Personnel Administration for Procter & Gamble, on whose behalf I appear today. With me, are Mr. John Lucia, Consultant, Employee Benefits and Policies, and Mr. James Bell, Manager, Corporate Health Care Benefits, who are knowledgeable about Procter & Gamble's health care plans in general, and the structure and content of our long-term care plan, in particular.

P & G was founded in 1837 in Cincinnati, Ohio. In the past one hundred and fifty years it has become one of the world's major consumer products companies, with over twenty billion dollars in annual sales in the 1988/89 fiscal year. The Company markets more than a hundred different brands in the detergent, paper, food, beverage and health care areas. P & G operates in all fifty states as well as in over one-hundred countries throughout the world. It employs 45,000 people domestically and another 33,000 in its international subsidiaries. About two thirds of P & G's business is done within the United States, and the other third is done internationally.

On behalf of Procter & Gamble, I appreciate the opportunity to testify before the Committee this morning on the role of business as it relates to the needs of the uninsured and the issue of long-term care. Both of these topics relate to such matters such as quality health care, long-term care, access to care, retiree health care, catastrophic care; and general cost issues which are currently being addressed by providers, employers, individuals and the nation.

It is important to state that Procter & Gamble believes these core problems are interrelated and require solutions that address all areas in a way that does not merely ask employers, who are already providing superior health benefits to their employees, to pay more of the bill. Doing this will force American businesses to carry in their product prices the cost of expanded medical benefits while simultaneously fighting for competitive survival in world markets.

As a business enterprise, we strongly believe in the value of the employer providing for the welfare of its people. We believe that the interests of the Company and those of its employees are inseparable.

In the Fall of 1981, we were one of the first national employers to introduce a cafeteria benefits program. As the needs of employees become more diverse, it is extremely important for Procter & Gamble to find ways of delivering benefits to accommodate individual circumstances and preferences. We are not advocates of the "one size fits all" philosophy. We have found our cafeteria benefits program to be a very effective way of providing employees benefits that meet their individual needs.

In the Fall of 1987, we offered long-term care to our employees, parents of our employees and our retirees because we felt it addressed an economic need and a societal problem. We think that these types of changes are best done in the private sector, but would agree that both the public and private sector must cooperate to ensure that all Americans are provided adequate health care.

For the majority of Americans, the delivery of health care coverage is a current reality that is taken for granted. Almost all individuals over age 65 enjoy a strong base of coverage through Medicare.

Of the individuals under age 65 with coverage, the vast majority derive their coverage from employer-sponsored plans.

It is clear that overall the private sector has responded well to the challenge of meeting the health care needs of those who are employment connected. This is the proper base on which to build by extending coverage to the twenty-five million people who have an employment connection, but do not have coverage.

Researchers estimate that about thirty-seven million Americans do not have public or private health benefit coverage. As mentioned, about two-thirds of these individuals have an employment connection. About two million are uninsurable due to medical impairments. The remainder, ten million, do not have an employment connection.

Because each of these population groups presents separate problems, it is appropriate that specifically determined initiatives be developed for each group:

Insurable Individuals with an Employment Connection

Of our nation's approximately 135 million employed persons and dependents, 80% are covered by employer sponsored health care plans. The remaining 20% account for two-thirds of the total uninsured population, twenty-five million out of thirty-seven million people.

Emphasis should be placed on attempting to find private sector solutions to covering individuals within this group rather than creating new government programs either to mandate coverage or provide care.

Employers have successfully provided coverage to the majority of working Americans and their families already. The knowledge and systems to deliver these benefits are largely in place. Where this isn't available, the government can help employers put it in place, but it should not try to take on this job itself since that could result in a potentially costly, slow, and inefficient solution.

Examples of how government can help include:

(1) exploring the question of whether favorable group insurance mechanisms could be further extended to small employer groups.

(2) providing for the tax deductibility of health insurance premiums in those cases where self-employed individuals themselves directly purchase health insurance policies.

(3) providing special tax incentives (perhaps limited tax credits) for small and low wage employers.

(4) providing assurance that the ERISA preemption principle is not eroded. This is critical because without it, there will be complexities and added costs for many employers which would work against extending coverage to more people.

The advantages of our increasingly market-driven health care system should be retained, and the benefits of the emerging, potentially more efficient managed care systems should be considered in developing recommendations to provide insurance for employed individuals not presently covered.

Insurable Individuals Without an Employment Connection

For those individuals in this category who can afford to purchase health insurance policies directly, incentives along the lines discussed in the preceding category would be appropriate. However, many people in this category may not be able to afford purchasing health insurance coverage. The problem of providing health benefit coverage for the unemployed should not be considered solely as an employer-related problem. It is a problem of society.

For the truly poor, public action through the Medicaid program is already available. This was recently done with respect to extending coverage to additional young children and pregnant women. Perhaps, consideration should be given to extending Medicaid at a reasonable rate to those who are economically disadvantaged but do not qualify for coverage under current criteria.

Uninsurable Individuals

It has been estimated that there are upwards to two million people in America who are not covered by employer sponsored health benefit plans and are unable to purchase individual health insurance policies because they have health impairments.

Procter & Gamble does not believe that employers exclusively should be required to finance risk pools for uninsurables. Employers are already providing about $127 billion of coverage for individuals. Providing health insurance coverage to individuals who are unable to obtain insurance in the open market is a societal problem, and thus it appears more appropriate to finance pools through general state or federal revenues or an expansion of the Medicaid program.

Legislative Barriers to Providing Quality Health Care

In its attempts to provide wider access to health care, we urge the Congress to use caution to avoid inadvertently creating barriers to health care that may reduce or eliminate what is currently being offered. Specifically, I'm referring to Section 89 of the Internal Revenue Code.

In my opening comments, I spoke to the fact that Procter & Gamble has a benefit cafeteria plan which we feel very good about. This plan provides the flexibility for our employees to tailor some health care benefits to fit their own needs. Current Section 89 discrimination testing rules make it difficult to maintain the non-taxable status of this kind of plan. Changes proposed under H. R. 1864 severely limit the ability to offer any non-taxable health care benefits to highly compensated employees through this kind of plan.

While the subject of the highly compensated may not appear to be a relevant issue in discussing access to health care. There are direct implications for the lesser compensated. The fact that the highly compensated may be penalized by the Section 89 approach makes cafeteria plans much less attractive in general for companies. Since they would not be able to provide benefits to all employees on an equal basis, there would be little incentive to develop or maintain cafeteria plans. In turn, this would deprive employees of the flexibility of choosing benefit options that best meet their individual needs. We do not believe this is the intent of Congress and urge you to reevaluate proposed H. R. 1864 rules as they relate to cafeteria plans.

We would also urge you to consider the subject of medical costs. In that connection, one area which needs scrutiny is medical malpractice liability. The number of claims and the size of awards in the non-auto sector of our liability system have soared over the past decade. Premiums for malpractice insurance are now about 1% of health care costs. Secondary costs of malpractice suits add substantially to that figure. In addition, the fear of such suits has led to the practice of costly "defensive medicine" in areas such as obstetrics.

Position on Long-term Care

Consistent with previous testimony, Procter & Gamble believes that the issue of providing long-term care should be pursued primarily through the private sector, rather than through government programs. This is the most effective approach to delivering services and controlling costs. The role of government programs should be limited to addressing the needs of individuals who cannot afford to pay for long-term care.

For most people long term care insurance protects their financial resources; it prevents long term care expenses from depleting their assets. A major social program that protects the estates of people who could otherwise insure themselves seems questionable.

Procter & Gamble introduced a long term care insurance plan to active employees in the Fall of 1987. By making this benefit available, the Company has provided employees a way to insure against the potential significant financial burden of long term care needs for themselves, their spouses and parents.

The Plan design details of P & G's long term care program will be provided to members of the Committee at the conclusion of this testimony.

Conclusions

Mr. Chairman, members of the Committee, we appreciate having had the opportunity to speak to you today and present Procter & Gamble's position on issues that are important and complex. We hope that our testimony has adequately conveyed the message that P & G is committed to quality health care coverage for its own employees and that we want other employers, if necessary with the aid of incentives, to be in a position to do the same. This alone will address a large part of the current and projected problem. In terms of the unemployed and uninsured, we, like most other good employers, believe the solution must be a societal response to a societal need.

Chairman GRADISON. Thank you very much, gentlemen.

Many businesses have been trying to control the inflationary spiral which has been pushing up the costs of medical care at about double the general inflation rate for, literally, decades, and so has the Government in its own insurance programs, such as Medicare, which is the largest of the health insurance programs in the country. None of us seems to have been terribly successful in doing that so far and, indeed, to an extent, many of the business plans seem to have the effect of trying to stabilize or slow down the rate of increase of costs for the business by shifting more of the costs to the employee.

Procter & Gamble has made major changes in its health insurance plans for employees, and I wonder if you could tell us, are they working? Are you slowing down the inflation rate? What's happening out there?

Mr. REINA. Procter & Gamble, 9 months ago, changed to a managed care health plan. Our experience to date is limited. We don't have a baseline on which to evaluate it totally. Early findings suggest that we have managed to slow down the escalation of health care costs. That is not to say that that's a solution. It's simply an improvement over what otherwise would have been.

So, we are hopeful that this emerging managed care system that we're experimenting with helps us to contain costs.

Chairman GRADISON. When you say you've slowed them down, are you talking about a slow down in the price that you pay providers or the volume of services or both?

Mr. REINA. Really, we're talking about the cost to the company in providing the same standard of quality health care that we've been able to provide in the past. We projected what our costs would have been, but are now not realizing those costs. We are holding total costs closer to costs of last year. There is some increase, but certainly not at the projected pace.

And, at the same time, we're able to offer, virtually, the same plan within a network that was offered to our employees 1 year, 2 years, or 3 years ago.

Chairman GRADISON. Is this being done at increased cost to your employees?

Mr. REINA. There's a minor increase to our employees. There is some cost sharing that didn't exist in the prior plan. The plan coverage is, essentially, identical, and now we're asking our employees to pay a small contribution toward that coverage, where that didn't exist in the past.

Chairman GRADISON. Do you have any questions?

Commissioner BALOG. Yes.

I was interested in the breadth of your coverage. I think you said it covers the parents of retired employees or of current employees?

Mr. REINA. With respect to long-term care coverage, it is the parents of current employees.

Commissioner BALOG. How do you treat your liabilities—I guess they are unfunded liabilities you must have. Could you guess? Is it true that you don't find these liabilities on your balance sheet currently for health benefits?

Mr. REINA. Mr. Lucia is knowledgeable in this area.

Mr. LUCIA. Are you speaking about health care benefits——

Commissioner BALOG. Yes.

Mr. LUCIA [continuing]. Or are you speaking about long-term care?

Commissioner BALOG. Health care benefits, in general. Do you do them on a "pay as you go," or do you provide——

Mr. REINA. We are self-funded. We self-fund for active employees on a pay as you go basis.

Commissioner BALOG. But, on a current basis, you don't have any reserves for future liabilities.

Mr. REINA. We currently do not.

Commissioner BALOG. Would you guess how much your unfunded liabilities would be if you had to state them?

Mr. REINA. I really couldn't say.

Commissioner BALOG. I guess by 1992, isn't it, you are going to—at least the Accounting Standards Board is indicating that you'll have to come up with some numbers as to how much your unfunded liabilities are and start putting them on your balance sheet. I'm just curious with a company like yours, which has extensive programs, it must be some fairly significant number.

Mr. REINA. The question is, have we researched what that unfunded liability might be?

Commissioner BALOG. Yes.

Mr. REINA. I know those studies are in progress. I don't have that information with me today. I don't have a number I can give you.

Commissioner DAVIS. Mr. Reina, when Procter & Gamble went to a managed health care system, what you did, in fact, was freeze your expenditure for health care, imposed upon your employees additional costs for the care, is that not what you've said?

Mr. REINA. Mr. Bell will answer that question.

Mr. BELL. No, that's not what we did, and I don't believe that's what we meant to say. We designed a plan that provided the same level of benefits that we had before under our so-called indemnity plan, but within a managed context, which means that employees have the choice of going to a network provider and receiving the full level of benefits they had before, or going to a nonnetwork provider and sharing in some of the costs.

But, the plan right now continues the same health care benefits without a significant shift of cost to the employees at all. There is a token contribution of $5 and $10 per month for single and family contracts in our health care program, but that's hardly significant in terms of the health care costs that are being incurred.

Commissioner DAVIS. But, outside the managed care, the employee does have to pay extra for it.

Mr. BELL. The plan outside of the network is fairly typical of industrial plans, being an 80/20 comprehensive kind of plan. It's typical of what most employers provide. Our managed care program provides better coverage.

Commissioner DAVIS. Do you have any evidence so far as to the quality we've talked about, the access and cost, of these two plans, the managed and the individual choosing their own care, have you any evidence that quality has dropped off, and that employees are opting for less coverage, things of this sort?

Mr. BELL. No, quite the contrary, sir, quite the contrary. About 80 percent of our employees, in fact, who are eligible for the managed care type of program, have selected it.

The evidence that we have at this point is mostly testimonial regarding quality, but it's very good. As a matter of fact, a number of employees have told us that by being connected now with a primary care physician, and getting preventive care, some longer term chronic problems have been discovered well in advance. They've gotten care earlier than they would have under our prior plan.

Commissioner DAVIS. Mr. Reina, Procter & Gamble is a large employer. Is it implicit in your feeling, in your corporate feeling, that you are not only covering your employees well, but through tax base and other means you are also paying, you are being double dipped into to help pay some of the health care costs of other smaller companies, and unemployed, things of this sort, people of that type?

Mr. REINA. That's something we are suggesting we would like to avoid happening, but we don't think——

Commissioner DAVIS. Is it happening now, do you think, over the recent years?

Mr. REINA. I think it is, yes.

Commissioner DAVIS. Thank you, sir.

Chairman GRADISON. I would like to ask one other question that this useful discussion has brought to my mind. With regard to the question of quality, how do you go about determining which physicians or hospitals will be on your network, or part of your preferred group, how is that determination made, and what systems do you have in place for monitoring whether those people who are on the list today, or those institutions that are on the list today, should continue to be there?

Mr. BELL. We have contracted with a carrier, Metropolitan Life Insurance Co. They are responsible for the selection of providers in the network. They have their own set of criteria, which are quite extensive, involving credentialing and other kind of statistical data regarding physicians and hospitals which suggest the kind of quality they provide. These are in terms of mortality, morbidity, and readmission rates: the kind of information that the medical industry can use to evaluate quality objectively. We do not choose to be involved with selecting providers, because we are not experts at this. But we do contract with those who are experts. We have confidence in their ability to select high quality providers.

In addition, there is constant review of those providers to ensure that, in fact, they are providing the kind of care that we expect. We've long had a high-quality health care plan and one that we've been very proud of. Our move to a more managed health care program was intended to provide that same high level of care that we've always had.

Commissioner BALOG. In a nutshell, why does managed care work? What does it do that the previous system didn't do?

Mr. BELL. I believe it has impact in two primary areas. One, it allows large companies like Procter & Gamble to take advantage of the large volume of patient business, if you will, that a large employer can direct. Therefore, it's in the provider's best interest to

negotiate contracts that allows them to increase the volume of their patients, but at some price reduction.

A second one we believe is through utilization management. Up until now, we have made attempts, with limited success, to try to control utilization. What I mean by that is, the unnecessary use of medical services, or the inappropriate use of medical services, which are terribly costly. We believe that our plan, through a carrier who can truly review medical decisions before they take place, will have a better chance of delivering appropriate, high-quality care that fits the needs of the employees and patients without running up the costs for unnecessary care.

Commissioner BALOG. So, it's volume, knowledge, and competition, if I can summarize it.

Mr. BELL. As one piece of it, and utilization control is the other piece.

Commissioner BALOG. May I ask one more question? I think Mr. Carroll in his opening remarks mentioned that the cost of health care would raise the cost of American business, and one would have to think about that in a global context of cost competitiveness. And, yet, America spends almost 12 percent of its GNP [gross national product] on health care, and most of our competitors spend far less, and their health care systems are, I guess, when one looks at the United Kingdom or Canada or Sweden, you get lower percentages of GNP. We are now already a high-cost producer in terms of medical care. How can we improve our medical care in America for the same percentage of GNP, or a lower percentage of GNP? Have you thought about that?

Mr. CARROLL. Only from a corporate standpoint. The comment I made was designed to illustrate that if employers are put in the position of having to pay an ever-increasing share of the country's health care costs, then our capacity to compete internationally is going to be reduced. Our prices would have to go up. The net effect of that is not going to be beneficial to the country.

Commissioner BALOG. Well, I guess what I was getting to, no matter where we put it, whether we put it on business or put it into wage or put it wherever, our aggregate cost level goes up. You can't hide it. It's that balloon again. Wherever you put it, it shows up as an aggregate cost in the globally competitive world.

Mr. CARROLL. And, I didn't mean to suggest that it shouldn't be controlled. It certainly should, and as some of our discussion has mentioned this morning, there are ways we believe to provide quality health care without ever increasing costs.

Commissioner BALOG. I must say, Procter & Gamble is certainly an extraordinary company in national, maybe even in global terms, of what it does for its employees, and it would be a wonderful model if everybody had your size and your competitive position and so on. It's a nice standard to shoot for, I suspect.

Mr. CARROLL. Thank you.

Chairman GRADISON. I have to put on my hat as an economist, I don't think it necessarily follows that this gets put into your costs. It probably or more likely would mean lower wages in cash than you otherwise would pay. Unless you assume that there is an unlimited amount of money that you can pay your employees, and that increased and fringe benefits will be piled on top of the cash

wages, which I think is unrealistic, then if certain costs of fringe benefits get too high, then the wage rates are unlikely to go up as fast as they otherwise would. There's still a cost in the economy.

But, from the point of view of an individual firm, it is not necessarily a net increase in cost. You are welcome to argue with that point, and I'm going to make the point and challenge you, because it seems to me that otherwise you end up with a wage level that's simply out of line in terms of your ability to pay wages within the framework of your own industry and your international competitive situation.

Mr. CARROLL. I think you are right on target, Congressman. The issue is that costs are going to go up, whether you put them in wages, in fringe benefits, whether you are capable of controlling or reflecting them in prices, at some point there does need to be the lid of which you spoke.

Presumably, one logical lid would be a reduction in health care benefits, which certainly seems to be inconsistent with at least the way in which Procter & Gamble approaches its employees. We haven't faced the decision as to whether we can continue to fund quality health care programs and continue to pay competitive wages. I hope we don't need to face that decision.

Chairman GRADISON. Thank you.

Any other questions?

Thank you very much for your extremely useful testimony.

We will now hear from Charles Brumfield, the director for labor relations for the American Telephone & Telegraph Co., and James Irvine, a vice president of the Communications Workers of America [CWA].

Welcome. Please, proceed. Thank you very much.

STATEMENT OF CHARLES BRUMFIELD, DIRECTOR, LABOR RELATIONS, AMERICAN TELEPHONE & TELEGRAPH CO. [AT&T]

Mr. BRUMFIELD. Thank you.

Vice Chairman Gradison, members of the Commission, my name is Charles Brumfield. I am director of labor relations for AT&T. My office is located at 1 Speedwell Avenue, in Morristown, NJ.

Today I would like to review with you the history of health care plans for union represented employees at the AT&T Corp., elements of the current plan and some changes that came out of the recently completed round of bargaining with the Communication Workers of America and the International Brotherhood of Electrical Workers [IBEW].

I should note that these contracts are still undergoing ratification by the union membership, which is due by July 7.

Furthermore, I will review the costs associated with the health care coverage provided to AT&T employees, and I will describe some of the efforts we have undertaken with the unions to jointly help control these rising expenses.

AT&T health care coverage, essentially, began in 1937, when we introduced hospital insurance on an "employee pay all" basis, utilizing payroll deduction.

In 1943, surgical insurance was added to hospital insurance, again with the employee paying for it through payroll deduction.

In 1960, we introduced a major medical plan, which wrapped around the hospital and surgical plans, in order to provide coverage for the full range of health care services to meet our employees' needs. The company paid the full premium for this first major medical plan.

Three years later, we introduced the basic medical expense plan, with premiums partially paid by the company, to replace the earlier hospital and surgical plan.

In 1966, we began a special medical plan for retired employees, which was intended to supplement Medicare.

In 1970, the company assumed payment of the full premium for the basic medical expense plan.

Two years later, the surgical and medical portions of our basic plan were changed from scheduled benefits to reimbursement of 80 percent of reasonable and customary expenses.

In the 1980 round of collective bargaining, we combined the basic and the major medical expense plans into one comprehensive health care package for all AT&T employees and retirees. This change was effective in 1982.

This 1982 plan is, essentially, the one we have today. Let me describe it for you. Our plan reimburses a substantial share of the reasonable and customary costs of the covered services employees and eligible dependents may receive each year. Just how much is paid depends on the type of care, where the care is received, and in some cases whether the care has been precertified or not. For simplicity sake, the examples I will give you assume that the care has all been properly precertified.

For hospital care, we cover 100 percent of the reasonable and customary charges for inpatient care. This includes a semiprivate room, board, and other services. Stays can last up to 120 days for each separate incidence for most conditions.

For outpatient services, we cover 100 percent of the reasonable and customary charges for minor surgery at any time, or if treatment is given within 72 hours after an accident or the onset of a sudden and serious illness.

We also cover 100 percent of the reasonable and customary charges of an ambulatory surgical facility and preadmission testing.

Additionally, we cover 100 percent of the reasonable and customary charges for alternatives to hospital care. This includes home health care, extended care facilities, and berthing centers.

For inpatient surgery, we generally cover 95 percent of the reasonable and customary charges. For surgery performed on an outpatient basis, the coverage is 100 percent.

For medical care in the hospital, we generally cover 100 percent of the reasonable and customary charges for such procedures as diagnostic x rays, lab tests, radiation therapy, chemotherapy, and electric shock. There is generally 90 percent coverage of administration of anesthetic, and in the hospital doctor visits and consultations.

We also provide coverage for chemical dependency and substance abuse and rehabilitation care. On an inpatient basis, this coverage is 100 percent for reasonable and customary charges. On an outpatient basis, it is 80 percent of the charges.

We have another category called other covered charges. This provides coverage for doctors' office visits, in connection with an illness, extended hospital stays, prescription drugs, and professional nursing services. A deductible applies to this category of expenses. The deductible for each covered individual currently is equal to 1 percent of basic pay, or a maximum of $150 annually. Coverage for the categories of services I just named, after the deductible is met, is 80 percent of reasonable and customary charges. Also in this category is outpatient psychiatric care, for which coverage is 50 percent after the deductible is met.

Our plan has an out-of-pocket maximum feature that puts a cap on how much employees have to pay for covered expenses in any 1 year. Once expenses for other covered charges reach $5,000, the plan pays 100 percent of any remaining expenses for other covered charges incurred during the calendar year. This means that no individual employee or their dependent faces out-of-pocket costs greater than $1,000, plus a deductible, in the calendar year.

The company pays the full premium for eligible employees, and what we refer to as class I dependents. These are spouses and each unmarried child, through the end of the year in which the child reaches age 19, or age 23 if a full-time student, or an unmarried child of any age who is incapable of self-support, physically or mentally handicapped, and fully dependent on the covered employee.

Coverage is provided at no cost after 6 months of employment to regular full-time employees and part-time employees regularly scheduled to have worked at least 25 hours a week. More than 1 million people are covered by the AT&T medical expense plan. This includes management and occupational employees, both active and retired, and eligible dependents.

As I mentioned earlier, on May 28 we concluded labor negotiations with the Communication Workers of America and their International Brotherhood of Electrical Workers. Health care was one of the most important issues we dealt with during those talks, and, certainly, was one of the most emotional ones.

While the union and the company approaches to the problem differed, we shared the same basic objective, to see that AT&T employees continue to be covered by an excellent health care plan, one that compares favorably with those offered by other companies. The union, obviously, wants that protection for its members. As an employer, we want it also.

The changes made during negotiation preserve the excellence of our health care plan, while contributing toward holding down the ever-increasing costs that the company bears. The rising cost of health care, and the quality of it, and the access to it are of great concern to AT&T and its unions. AT&T's health care costs this year will be about $1 billion. These expenses have been growing at an average of 13 percent annually over the past decade.

In spite of some cost containment measures arising from our latest round of bargaining, we expect cost increases in the near future to average about 10 percent a year.

Let me briefly describe some of the cost containment measures coming out of the recent contract negotiations. The application of a deductible will be expanded to include certain hospital services. For those earning $50,000 a year or less, the deductible will be $150

for each individual. The deductible will increase on a sliding scale for those earning more, with the maximum individual deductible being $300.

We also will be initiating the use of health care networks, groupings of physicians and hospitals which agree to give AT&T employees negotiated lower rates for quality health care services. Employees who use these networks, where available, will have a greater percentage of their costs covered and a lower deductible than those who choose not to use them.

We also took steps during the bargaining to limit the liabilities the companies face over the long term in the area of postretirement health care benefits. Let me reiterate that it has been and remains our intention to see that AT&T employees, active and retired, continue to receive excellent health care in this country. At the same time, we entered the 1989 negotiations knowing we had an enormous expense problem to deal with. We are very pleased that we were able to work with the unions during bargaining to come up with solutions that address the cost problem, while still maintaining a very attractive medical expense plan.

The partnering between AT&T and its union, to contain rising health care costs, is an effort of long standing. With one exception, each triennial round of bargaining since 1977 has created a joint union/management health care cost containment committee. Out of this partnership has come a number of approaches to controlling health care expenses. These include: Preadmission testing; alternatives to hospital care, and the implementation of precertification processes. While most of these measures have somewhat helped hold down cost increases, our expenses continue to rise at an alarming rate.

We are a large company, with more than 300,000 employees. The CWA and IBEW are large unions with hundreds of thousands of members. Out of this last round of bargaining came the realization that, as large as we are, the health care dilemma is bigger than AT&T and its unions together. It is truly a national issue.

Therefore, the contracts we have just negotiated pledge that AT&T, the CWA, and the IBEW will work together to help bring about a national solution to this problem. Where we can share our experience, our expertise, or speak as one voice to hasten national solutions, we will do so.

Furthermore, we invite other groups from labor, business, and the community to join us in a coalition that will promote the cost-effective use of health care dollars, and, at the same time, improve the quality of and access to basic levels of health care coverage.

Today is one of the first occasions on which we have been privileged to speak with one voice about health care. On behalf of AT&T and our partners in the CWA and the IBEW, I wish to thank you for this opportunity.

Chairman GRADISON. Thank you, Mr. Brumfield.

Mr. Irvine?

STATEMENT OF JAMES IRVINE, VICE PRESIDENT, COMMUNICATIONS WORKERS OF AMERICA [CWA]

Mr. IRVINE. Good morning, Vice Chairman Gradison. My name is James Irvine, and I am vice president of the Communications Workers of America, in charge of the union's bargaining units at AT&T.

I am here representing the 700,000 members of the Communications Workers of America who work in the telecommunications industry, in State and local governments, and in the health care industry.

The members of our union believe health care is a right. We believe access to adequate and quality care should not depend on the wealth of a person. We believe every citizen of our country should have the health care they need when they need it, not just when they can afford it.

In our country, access to the health care is made available either through Government programs for the poor and elderly, or through private health care insurance. Since the cost of health insurance can be quite high, CWA has always worked to achieve quality employer-paid group health insurance programs to cover our members' needs and health.

We believe that every worker should be covered by a full-service, fully paid health care plan, and that it is in the interest of every employer to provide such a plan. This has been the guiding principle behind CWA's health care bargaining. Quality health care benefits preserve the economic security of workers and their families during periods of medical emergency and ill health, and they protect the employer's investment in each employee.

Do our members need good health care benefits? You bet they do! CWA members are not wealthy. The average CWA member employed in AT&T earns slightly more than $26,000 annually. This is a modest but decent living in today's day and age. However, the take-home pay from that wage can be quickly wiped out by expenses incurred as a result of a serious illness or medical emergency.

During such events, a package of good comprehensive health benefits far outweigh the value of a modest wage increase. Our members should not have to go broke to keep themselves and their families healthy. That is why this union has always placed health benefits as one of its top bargaining priorities. These benefits, however, are not free. The health benefits that workers at AT&T have won during collective bargaining are charged to the labor contract. In some cases, we have paid for the benefits by accepting lower wage increases than might otherwise be available in the absence of a good benefits program.

There is a give and take in the collective bargaining process that means nothing comes free. Because our health benefits are charged to the contract, CWA is sensitive to the increasing costs of providing a quality health care program. That is why in the early 1980's the union proposed some cost containment initiatives. As a result, the company implemented utilization review, preadmission certification, second surgical opinions, and a variety of outpatient and preventive care programs. These programs were designed to pre-

vent unnecessary and costly hospital stays. The new programs are responsible ways of containing health care costs while maintaining comprehensive coverage.

Importantly, these cost containment programs have fundamentally changed the way our members utilize the health care system. No longer does the health care provider have the sole discretion over the kind of care our members receive. Our utilization program at AT&T, called health check, serves as a gatekeeper to assure that the care prescribed is appropriate for the diagnosis.

In spite of these significant accomplishments, health care costs have continued to rise at AT&T and nationwide. With no end to health care cost increases in sight, the debate at our bargaining tables is over who should pay for the increased costs.

Simply put, employers do not want to pay what it costs for health care. They want workers to pay for the increased cost of health care, even though employers, particularly in the financially robust telecommunications industry, can absorb the rising costs more easily than the individual. We call this strategy cost shifting.

CWA is opposed to cost shifting because it exposes workers to rising health care costs and restricts their ability to meet their health care needs. Since higher costs act as barriers to care, everyone loses. People delay receiving needed treatment, or do without, or find themselves financially strapped during a medical emergency or a serious illness. Employers suffer losses in work satisfaction and productivity and create an increasingly unhealthy workplace.

But, most importantly, cost shifting simply does not contain health care costs. It only reduces employers' expenses. Health care costs will continue to rise no matter who is paying the bill unless reform is aimed at the health care delivery system itself. That is why during our recent negotiation with AT&T the CWA, along with the International Brotherhood of Electrical Workers, rejected company attempts to shift costs to workers.

We proposed instead that the company establish a network of preferred providers, and we won coverage for mammograms and nurse midwives. These benefits will help promote preventive health and encourage use of more cost-effective providers.

But, ultimately, health care costs cannot be controlled at the bargaining table. Thus, CWA and the IBEW also proposed that the company work with us to promote and achieve national health care reform.

We are happy and proud to say that AT&T accepted this proposal. Our agreement on this issue reads in part; "In the past, the parties have mutually agreed to attack this growing crisis * * *," that is, the rising health care costs, "* * * by adopting various cost containment measures in the medical expense plan. While these steps have been continued in these negotiations, as in the past, to respond to those rapidly escalating costs, it is clear that the problem cannot be solved at the bargaining table. The triple problems of access, cost, and quality of care are national problems, requiring comprehensive national solutions. Therefore, the CWA, the IBEW, and AT&T now agree to mutually work to achieve prompt and lasting national solutions to curb this crisis."

This agreement was reached on May 27, 1989, and we are preparing to develop our mutual plan of action. However, from CWA's perspective, any solutions to the health care crisis must address the root causes of rising costs. Some of the causes are: Physicians who prescribe excessive treatments; hospitals that expand and capitalize inefficiently; and, employers who do not provide group insurance for their workers, and the lack of coverage for the rest of the 37 million uninsured Americans.

At the same time, reforms must enhance the best elements of our system, which include equal access to quality care, a pool of skilled and productive health care workers, and ongoing research and development of more effective medical treatments.

I tried to structure my remarks to give the Commission members an idea of how the Communications Workers of America is working to preserve one of our most valuable bargaining games, health benefits.

In summary, this union is keenly aware of the rising costs of health care, and we are more than willing to work with our employers to develop ways to control the health care costs. However, cutting our members' health care benefits, which could limit their access to health care, is simply not the solution to the health care crisis. The problem of rising health care costs is a national problem requiring national solutions.

If you have any questions about my remarks, I'd be happy to answer them to the best of my ability.

Chairman GRADISON. Thank you both, thank you very much. That was very useful testimony for sure.

Mr. Brumfield, are any plans offered by American Telephone in the long-term care field at this time?

Mr. BRUMFIELD. No; they are not.

Chairman GRADISON. Mr. Irvine, you made a comment which I'm sure is so, you said our employers simply do not want to pay as much for health care as it costs. I couldn't help but think as you said that, our constituents have much the same feeling. And, one of the things that is so difficult from a point of view of public policy is that, while there seems to be a very broad awareness around the land that everyone should have a means of paying for health care, there don't seem to be a lot of people wanting to walk up the line and offer to help pay for it, especially people who already have a reasonably satisfactory means of paying for health care right now.

Isn't it inevitable if there is some more comprehensive national plan that American Telephone and its employees will be asked to help pay for it?

Mr. IRVINE. Well, that might well be, and I think we'll step up to that issue should it occur.

There is, of course, the legislation, the Senate bill 768, and House bill 1845, that discusses at least the base on which we could build from in the private employer sector.

I think that——

Chairman GRADISON. Is that the mandatory employer coverage bill?

Mr. IRVINE. Yes.

Chairman GRADISON. Kennedy-Waxman?

Mr. IRVINE. Kennedy-Waxman, yes.

Chairman GRADISON. Are both of you supporting that?

Mr. IRVINE. We haven't talked this yet. I suspect Mr. Brumfield might hold a different view of that.

Mr. BRUMFIELD. We have no comment on that today.

Chairman GRADISON. Well, let me pursue this in a more general way. My understanding is that very recently you have agreed to work together, which I applaud——

Mr. IRVINE. Yes.

Chairman GRADISON [continuing]. In seeking a more comprehensive national solution to these gaps in health care.

Am I correct then that you haven't yet gotten to the specifics of what you are going to recommend? Is that right?

Mr. IRVINE. Yes; I believe in my testimony I said that.

Chairman GRADISON. Yes.

Mr. IRVINE. This——

Chairman GRADISON. What is the timetable for trying——

Mr. IRVINE [continuing]. Well, this contract hasn't been ratified yet.

Chairman GRADISON. Yes.

Mr. IRVINE. The date on that is July 7. Once that occurs, then we'll get together and begin talking through that issue and develop some strategy.

Mr. BRUMFIELD. I think today, this is the first time that the company and union has had the opportunity to sit down, where we are both going to try to approach the problem from the same point of view.

Mr. Irvine pointed out in his testimony, in our recent bargaining we were coming at the problem from two different angles, and we've ended up with a proposal that we not only involve our employees, our company, and unions, but that we try to involve everybody who is faced with this problem, and that's our objective as soon as the contract is ratified, which does not necessarily mean legislative solutions as a part of the overall program.

Chairman GRADISON. Thank you. We'll look forward to your recommendations, but we're hearing more and more from business people that, for major, very large companies, that they can't solve this alone, that something more needs to be done on a national basis, particularly with regard to these major gaps. However, in frankness, it gets a little vague at that point about what they think ought to be done, and I don't blame them, it's a little vague when people ask me what ought to be done.

Jim?

Commissioner BALOG. I think in any event, we ought to have Mr. Irvine on our side in this bargaining.

You mentioned in your remarks that your average wage is $26,000, and that there was some give up in out-of-pocket wages for the health benefits, and I think in your testimony you said: "* * * and, therefore, we pay for it." I think this is near and dear to Congressman Gradison's heart, because he picks me up on that every time I say: "add it to the wage base," he says: "No, no, the wages may be lowered."

Question. How much do you think the health care benefit package costs, what are you giving up in wages, and what are you,

AT&T, paying for this benefit package per year to add to the $26,000 average?

Mr. IRVINE. Can we confer here?

Commissioner BALOG. And, you may have a different answer, each of you.

Mr. BRUMFIELD. Well, the numbers, with 300,000 employees and $1 billion, that's over $3,000 an employee, isn't it?

Mr. IRVINE. Right.

Mr. BRUMFIELD. I would only say that our current costs are running somewhere, and these will just be ranges, of somewhere between $2,650, and this is all categories of employees and dependents, about $2,650 to $2,950 per year.

I think it is true in the bargaining process at the last round of bargaining, the company had a lot of bargaining proposals on the table that Mr. Irvine would characterize as cost shifting proposals by the company.

When we ended on the 27th, we ended up with a situation where the company did not achieve some of its major bargaining objectives, which were some cost shifting proposals. At the same time, while you can't equate it to an exact dollar amount, other areas of the package, and I was glad to hear Congressman Gradison say that a while ago, there is a tradeoff, in collective bargaining units there is always a tradeoff, and I'm quite sure that the union in bargaining other aspects of the contract, like a profit-sharing plan, or things like more improved care in the area of some of our dental schedules and vision schedules, they were not improved to the extent that the union thought should have been there, and those are the tradeoffs in the collective bargaining procedure.

I agree with you, it's a big pie. Sometimes the pie grows, but portions of the pie somewhat stay the same, unless you are willing to shift them.

Commissioner BALOG. One last one. I was struck by the fact that your plan has so many features that are 100-percent payment, first-dollar coverage on everything, and then when you get into these others, you start having copays and so on.

Let me put in the positive sense, what is the virtue of deductibles in limiting the usage patterns, excessive usage, waste patterns, because I notice your plan is 100-percent coverage, first-dollar coverage. It seems to me that you don't have the benefit of the patient having to be somewhat of a referee on what's to be done, because he has nothing to pay.

Mr. BRUMFIELD. I wish we had you at the bargaining table. That was one of the points we were trying to make.

Mr. IRVINE. It took them 25 years to get to that.

Mr. BRUMFIELD. No; we were, with the union's concurrence, and with the union's help, able to point out that some of our plan design was not conducive to controlling cost, and while we backed away from such things as premium sharing and things of that nature, we did move the deductible up front on some expenses, whereby now the employee would incur the deductible before, in other words, the first-dollar coverage on some of our areas is no longer there.

But, the valuable portion of our plan to our employees is that, while Jim pointed out the average wage is $26,000, people up to

$50,000, and that's the very high end, still only pay $150, and the most you can ever pay, we have no lifetime max, we have no annual max, the most an employee will pay is $1,150, and that's if the charges are $10 million.

Mr. IRVINE. There were some areas where we saw abuse, and I think we covered those in bargaining this year. If a person would utilize an emergency room or a hospital, knowing that there would be 100-percent coverage, instead of the $150 up front, we shifted that so that they would have to pay that, where people would take a child into an emergency room and clog up the emergency room because they had a fever, rather than utilize a doctor. So, we shifted that from 100-percent coverage over to the $150 deductible.

Commissioner DAVIS. Mr. Brumfield, I was very interested in the fact that you have stopped your mandatory second surgical opinion. Was that difficult to accomplish?

Mr. BRUMFIELD. No, it was not. In fact, it was a union suggestion, we all have a boss, and Jim's boss, Morty Barr, the president of the CWA, Workers of America, called our company's vice president of labor relations and said that this is something we really need to take a look at, because a lot of the forums that he was attending around the Nation, he was getting the message that while it sounded real good when we put it in it wasn't working, and we found out that not only were we paying for the second opinion, but we were paying for the surgery at 100 percent after the second opinion. So, instead of reducing cost, it was actually adding to our cost.

Commissioner DAVIS. I raise it only to commend you. I happen to be a surgeon, and we've been opposed to that for a long time. No, we benefit from it, but it's terrible. As a surgeon, if I see a patient who has a hernia, a rupture, or has gallstones and needs to have their gallbladder out, they've been seen by their medical doctor, the internist of family physician, and then they are seen by a surgeon who says, yes, I concur, they ought to have the operation. Then the industry has required a second surgical mandatory opinion, and so, we've been getting paid for doing little or nothing because the need is obviously there. I commend you on doing this. This is setting a pattern for the country, and I think we can save considerable money by encouraging voluntary second opinions whenever either side wants it, but cutting out mandatory second opinions. It really is not cost-effective.

I was interested in the fact that you said you were working together, and was going to ask what your game plan is, but I gather from your later statement, it's too early to ask that. Is that right, how you together are going to address a national issue of health care costs?

Mr. IRVINE. It's not too early to ask, Mr. Davis, it's too early to answer.

Commissioner DAVIS. Well, I encourage you to do that. We need industry and labor under the table at the same time as the rest of us are.

Let me commend you, Mr. Irvine, on your statements about the "shiftor" and the "shiftee," and the fact that nobody wants to stand up and pay for health care at what it costs to provide it. And, to needle the Congressman a little bit, in saying that we have had

a nice little example set for us, in that the Federal Government has done this to a beautiful degree, that they have failed to pay the costs of providing care for Federal patients that they have encouraged to utilize and have not paid the going costs of providing the care, therefore, requiring hospitals and others to shift those costs into the private sector. And, I think you are exactly on target on that, and we've got to make sure that the Federal Government meets its obligations or tells the people that they are not covering them completely.

In 1965 Medicare said, yes, you have a right, you have access to health care; we will pay for it. Several years ago, they started cutting back and not paying at the total rate. They are shifting that to the private sector.

Thank you for bringing that up.

Chairman GRADISON. I have to comment on that, Dr. Davis. We are trying to be prudent purchasers.

The Federal Government, like business, historically hasn't bought health care, it's paid for it, and that system—I mean, unlike most everything else that business and Government buy, it's just been a matter of paying the bills. Starting in 1983 with hospitals, we moved away from a cost-based system. Maybe we moved too far, but the costs were simply getting out of hand, with the cost-plus or cost-based system, and now we're going through, as you know, the very difficult and controversial question of how to deal with the very rapidly rising costs of physician services. It's not easy, but we're working with limited funds, just like everybody else. I appreciate your needle, but I just felt you'd want me to respond.

Commissioner DAVIS. May I define my idea of a prudent purchaser as one who pays for what he contracts to buy, not to contract for everything and then to pay 80 to 90 percent of that for which it has contracted.

Chairman GRADISON. I think in fairness to the witnesses, let us move on. You can see we've got some differences of opinion among the 15 of us, and that's healthy, that was intended.

Commissioner BALOG. May I have one more?

Chairman GRADISON. Of course.

Commissioner BALOG. It kind of goes along with what you are talking about here.

Clearly, and I better get this in because we've had two witnesses now with plans I think that are above the national average. I think most people in this room would agree that the place to work is Procter & Gamble or AT&T, if you need medical coverage.

Clearly the expenditures by the companies for the employees are above an average. Let me ask Mr. Irvine and Mr. Brumfield if they want to comment on it. What would you think of an idea of calling those above average benefit costs taxable wages, and tax those benefits above the average, so that eventually you would move the average up and shift some of the burden of that to the people receiving higher than normal benefits? How would you react, or, rather, how violently would you react to that position? Would you make that your contribution to the national health care scheme?

Mr. IRVINE. We, obviously, would have some difficulty with that perspective. However, I think that with the graduated tax that re-

flects the—really reflects people's earnings, something like what happens in other countries, after all, as an American male, if I lived in 17 other countries, I could probably live longer. If I lived in the Scandinavian countries, my life expectancy would be 5 years higher.

So, it seems to me that there ought to be some other way to help pay that. I don't know that what we've done with the catastrophic legislation is really the answer, though. I expect, though, that we'll have a lot of difficult and thorny conversation with AT&T as we try to provide a single voice in the public debate on this issue, because it does really cry out for resolution.

Chairman GRADISON. I think it would even help with regard to financing if you can share with us later on the areas of agreement and of disagreement. I spend most of my life in the health care field, and my associates do too, in different ways, and, frankly, about 95 percent of what I hear at meetings and what I read in studies with regard to these subjects is about the benefits that ought to be provided. I don't think 5 percent is devoted to how to pay for it.

Frankly, I think the group of us here in the room could work out the benefit package before the afternoon was out, but how to raise this kind of money isn't easy. In fact, it may even be impossible in this environment where there's such a negative view toward increased taxes. Heck, there's a negative view toward the present taxes.

And so, even if you can't agree, it would be helpful to see on what points you disagree and why that disagreement is there. I think this would help us think our own way through these issues. We look forward to your further comments as your process proceeds. I hope ratification is a success, and, Mr. Brumfield, and, Mr. Irvine, thanks for sharing your day with us.

Mr. IRVINE. Thank you.

Mr. BRUMFIELD. Thank you.

Chairman GRADISON. Our next witness is Paul Policicchio, international vice president of the Service Employees International Union, AFL-CIO, and president of the SEIU Local 79 in Michigan.

STATEMENT OF PAUL POLICICCHIO, INTERNATIONAL VICE PRESIDENT, SERVICE EMPLOYEES INTERNATIONAL UNION, AFL-CIO AND PRESIDENT, SEIU LOCAL 79, MICHIGAN

Mr. POLICICCHIO. Good morning, Congressman Gradison, Mr. Balog, Dr. Davis. My name is Paul Policicchio. I'm vice president of the Service Employees International Union, AFL-CIO. With me today is Peggy Connerton, who is director of our international union's public policy department.

I'm substituting this morning for my president, John Sweeney, who wanted to accept your invitation to appear this morning, but was already committed to health fund board meeting which could not be rescheduled.

I am pleased to be representing my union, and President Sweeney, and pleased to be here on my own account. For my part, I serve in the State of Michigan on the Public Health Advisory Council, the highest ranking statutory advisory council, as well as

two other task forces, one a Governor's task force on access to health care, and, second, the Governor's health care cost management team, both of which are addressing the twin issues of access to care and cost of health care.

As the chief officer of an 18,000-member local union headquartered in Detroit, I'm extremely familiar with the problems in establishing and maintaining work-site-based health coverage. Like all working Americans, the members of our union are concerned about the health coverage of their families and troubled by seemingly endless increases in health costs.

As low-wage service workers, such as janitors, nurses aides, and office clericals, most of our members have never had a level of insurance coverage that industrial workers traditionally enjoy.

As a consequence, the effort to gain access to care, and the fight to control the health care costs, are key issues for us in our organization.

Service Employees is also the largest union of health care workers in the United States, and, as such, has a special mission to bring the views and concerns of caregivers to the health policy debate.

When the AFL–CIO Executive Council created a committee on health care 4 years ago, to coordinate the various health care activities of organized labor, we were honored by having President Sweeney chosen to chair that committee. He has also been a member of the National Health Cost Containment Coalition, chaired by former Secretary of Labor, John Dunlap, since its inception. He serves on the Health Security Action Council, which recently put forth a plan for national health care that was authored by Professor Rashi Fein.

As the only union member on the National Leadership Commission on Health Care, President Sweeney has been active in the search among labor, management, and providers for a common ground solution to America's health care dilemma. He also serves on the Implementation Committee of the Health Policy Agenda for the American People, and worked extensively on the Medicaid reform report that group issued earlier this year.

He was pleased to be appointed recently to the HHS Advisory Council on Social Security, a group with some promise of becoming a forum for the administration and consideration of health reform.

Finally, through his position as a board member of the National Health Care Campaign, he is active in trying to bring the concerns of individual users of health services to our national policy debate.

On behalf of the 925,000 members in our union, and the AFL–CIO Health Care Committee, we want to thank the Bipartisan Commission on Comprehensive Health Care, its new chair, Senator Rockefeller, and its vice chairman, Congressman Gradison, for the opportunity to appear today.

We are pleased to have this chance to share with the Commission the experience and perspective of organized labor in an area of traditional union activities on behalf of our members' health insurance coverage.

We are pleased, too, to be appearing with some of our labor and management colleagues who struggle daily to provide working

Americans with ready access to quality health services at an affordable cost.

Negotiators from the Communications Workers of America, the International Brotherhood of Electrical Workers, and the management of AT&T recently concluded a new collective bargaining agreement where a key issue was what to do about health costs, as we just heard. Their settlement combined problem solving in the best tradition of collective bargaining, with historic commitment to work jointly for national health reform.

Labor and management negotiators in the telecommunications industry are no different than their counterparts in other sectors of our economy. They have implemented the cost containment measures recommended to them, encouraged, argued, and cajoled workers and their families into more cost-conscious arrangements, and otherwise did all they could to preserve the health benefits for their work force.

In the early 1980's, when we faced double-digit increases in insurance premiums, employers responded by devoting a larger share of their operating budgets to health insurance, instituting cost containment programs, and shifting additional costs to workers, forcing their employees to pay more out-of-pocket costs.

Where labor and management work together to control costs, instead of simply shifting the financial burden onto workers, a variety of innovative cost control programs were introduced, including mandatory second opinion surgery, utilization review, and a variety of managed care programs. For a while, such cost containment initiatives seemed to have a tangible effect in holding down inflation in employer-sponsored health plans, but after hesitating in 1985 and 1986, health insurance premiums began rising faster than ever. In 1988, the premiums were up 20 to 30 percent, and today insurers are asking for another 30- to 40-percent increase.

In 1989, unions and companies are facing a renewed challenge on health costs, but now effective cost containment programs are harder to come by. Most plans have done what they could to trim the fat. Given the current organization of health services in the United States, further cost savings can be secured only through controlling outpatient costs, reducing benefits, or asking employees to pay even more out-of-pocket.

The labor movement has played a major role in developing the network of private health insurance that, through its coverage of some 65 percent of Americans, is the backbone of the health coverage in our country.

On the plus side, it's a system under which business, labor, and Government work together to increase the number of people with health coverage steadily until the early 1980's, but unabated health inflation, health care inflation, and the lack of an effective public policy to control costs, or ensure access, has severely, perhaps fatally, injured that arrangement.

It's common knowledge that of the 37 million uninsured people in our country, two-thirds are full-time workers and their families. Some of those uninsured are union members. Many more of them are the low-wage service workers our union struggles to represent.

What is just beginning to become known is the extent to which employers have erected substantial barriers to needed care among

those still insured, as they push a larger share of rapidly rising costs of coverage onto their employees.

The combination of these two trends, more jobs without insurance, and more jobs with unaffordable insurance, means that the private insurance base of our country's health care is deteriorating rapidly.

This year, as medical care inflation returned with a vengeance, unions faced renewed pressure for benefit take away, and an increased threat of strikes over health insurance. That's why recent agreements to maintain health coverage, such as were reached in the telecommunications field and the steel industry, are so important, because they show determination of unions and employers to hold to the principle that family health coverage should be provided every worker in this country.

But, even more important than the work of these groups in holding the line on health benefits is their leadership on behalf of a national solution to the American health dilemma. More and more, it's becoming clear that our traditional approach to providing and financing health coverage simply won't withstand the current intense cost pressure, at least not in today's competitive economy.

In order to measure the effects of health care inflation and the extent to which service workers were at risk for medical expenses, the Service Employees International Union surveyed a sample of plans in 1987, and, again, in 1989, covering roughly one-fifth of our 925,000 members. Today we are releasing the results of these surveys and copies have been provided to the Commission.

This look at what's happened to health coverage in a very large sample of service workers, our survey covers some 190,000 members of my union, will, we hope, be useful to the Commission in its deliberations.

And, I wanted to devote the remainder of my remarks this morning to a summary of this study. I will leave to President Sweeney on another day a discussion of the pros and cons of the various proposals now emerging for the best way to reach the goal of quality affordable health care which business and labor shares. Just as an aside, however, I would point out that as we in Detroit, MI, look to our neighbors south of us and see that they have a different system of health care that provides for lower health care costs and provides for more access to a broader segment of their population, we see that there must be something to be looked at in that system. And, if you are scratching your head, Congressman Gradison, I'm not referring to Toledo or Cincinnati, I'm referring to Windsor, ON, which is south of Detroit.

Our survey included a broad cross section of both public and private employers in 16 States and the District of Columbia. The plans have several important characteristics. First, and most of the employees surveyed, approximately 90 percent, are in plans covering white collar jobs in State and local governments with relatively good wage standards and benefit packages, including family health insurance. Currently, the average annual wage of these workers is over $28,000. Almost all the plans introduced extensive cost containment measures in the 1980's.

The remaining 10 percent of the workers surveyed are in plans covering low wage, janitorial, health care, food service, and clerical

jobs, where the average annual pay is $9,000 and health benefits are limited to basic services. Few cost control programs exist in these plans.

Second, nearly two-thirds of the 178 plan options surveyed were health maintenance organizations, HMO's, or preferred provider organizations, PPO's. The rest were traditional feed for service plans. The high penetration of HMO plans in the sample should mean that workers out-of-pocket expenditures are lower than they otherwise would have been.

The study paints a bleak picture for the future of employment-based health insurance. Among the major findings, first, health coverage obtained through private insurance, for middle-income workers, is in great danger due to a sudden large jump in employee share of the cost of just coverage. For low-wage workers, coverage has become virtually unaffordable.

Employers responded to recent cost re-escalation by shifting additional costs off their budgets and onto employees. Worker premium contributions for family plans in our survey jumped 70 percent over the 2 years, doubled, doubled the average 35-percent rise in employer contributions.

Deductibles and copays followed suit, even though wages went up less than 10 percent in the same period. As a result, middle-income families in indemnity or PPO plans find themselves at risk for medical bills as high as 20 percent of after-tax income, significantly above the level considered to be acceptable. If current trends continue, these workers will be paying nearly $5,000 a year for routine care within the next 5 years.

Low-wage service workers in the private sector are even worse off. Although technically insured, these workers can hardly afford the coverage offered to them because of the high contribution requirement, and consider my union, a union which represents health care workers in a system where the workers cannot even afford or obtain the very product that they provide. Consider a society where, for instance, auto workers couldn't afford to purchase the products of their labor, that's the system that we're getting into here.

The study finds that more than one-third of the disposable income of these workers would be required for premium contributions and deductibles alone, expenses which must be paid before insurance coverage kicks in. Total annual medical bills exceed after-tax income for the average worker in this category.

The second conclusion, rapidly rising health premiums crowd out other improvements in the compensation package and erode the wage base of both middle-income and low-wage employees. By taking more of the cost of health benefits out of workers' take-home pay, employers are further contributing to the declining standard of living.

Since 1987, payroll deductions for health premiums, adjusted for inflation, rose 56 percent for family plans, while real weekly earning stagnated. Since 1980, health premiums grew an average 15 percent annually, while consumer prices rose at an average rate of 4.7 percent a year.

If health premium increases had been held to the level of general inflation, the cost savings could have funded wage increases of 1.5

percent annually. That adds up to a total of 12 percent in lost wages over the last 8 years. Thus, health care inflation may be a major contributing factor in the stagnation of real wages over the last decade.

The third finding, nearly a decade of private cost containment initiatives has failed to win the war on health inflation. Many employers, convinced that cost containment measures would provide long-lasting savings, were taken aback by the recent resurgence of inflation. Employers' disillusionment with private cost containment is supported by the study finding that such efforts are no longer effective in slowing the rate of growth of health premiums.

Our study shows that cost control measures heralded in the early 1980's haven't achieved ongoing savings. Since 1987, health premiums in our sample plans have jumped an average 19 percent annually, more than double the rate of medical inflation, which is 7 percent annually, and 4 times, 4 times the increase in the Consumer Price Index, which rose at 4.4 percent annually.

The findings in our survey support the conclusion tha 'he problems of declining access and inflation are beyond the reach of the current system of employer-provided insurance. Again, restating, the conclusion is that the problems of declining access in inflation are beyond the reach of the current system of employer-provided insurance.

At this point, cost containment amounts to little more than each plan trying to shift costs elsewhere in the system, with all parties claiming no responsibility.

The worst offenders, the worst, are those employers who fail to insure their workers, forcing other employers providing health insurance to subsidize these offenders through higher surcharges on medical bills and tax-supported health care. Such cost shifting now accounts for roughly one-third of the annual double-digit increases in health premiums.

Unfortunately, there is nothing to be done about it on an employer-by-employer basis. The present moment requires strong Federal leadership to steer us out of the dangerous cross currents of rapidly rising costs and diminishing access.

We urge the Commission to weigh all the reform proposals which are now being put forward, and to bear in mind the lesson of labor's experience in recent years, that private insurance arranged on a voluntary basis is falling substantially short of the mark. We need a plan to move quickly to ensure universal access with effective cost control mechanisms and new standards and quality assurance. We need, in short, systemic reform carried out at the national level.

Our country lost a great public servant, and our people, one of the most effective champions last month, when your chairman, Congressman Pepper, passed away. We are fortunate that the Commission is so well supplied with leadership that it is able to sustain such a loss without diminishing the prospects of an excellent report later this year. No more fitting tribute to Claude Pepper could there be than your report, a call for action so clear and so compelling that it break the policy logjam which has encumbered us these recent months.

We know the Commission is equal to the task, and you have every best wish for your success in your endeavors. Thank you very much for this opportunity.

Chairman GRADISON. Thank you very much for that excellent, excellent testimony, and for sharing the survey with us. From what I know of the private scene, it's right on point, and right on target, and it seems entirely accurate.

I guess my main reaction is that I sense at the end of your statement you are a little more optimistic maybe than some of us who are dealing with the existing Federal health care programs about the ability of the Federal Government to deal with the problems of access and quality and cost. We've been trying with the Medicare Program, which, in a sense, is the largest health insurance program in the country, with very mixed results. You can even hear from some of the discussion up here, some controversy about what next steps should be taken, as well as the argument that we're not paying enough now, and, therefore, that we're responsible for part of the shifting, which you mentioned very appropriately. That one-third you mentioned is about right from everything I've seen.

Mr. POLICICCHIO. Well, as you know, Congressman, those of us in organized labor must be eternally optimistic after what we've been going through.

Chairman GRADISON. Well, you've got to be an optimist to be in my line of work too.

Commissioner BALOG. I couldn't let this occasion pass by with somebody that has the inside knowledge of the health care system, somebody representing the workers. And, in a nutshell, what do you think is the driving force, or forces, behind the cost increases in the medical care system in this country?

Mr. POLICICCHIO. I don't think you can just single it down to any one point. I think there is a number of factors. I will say this, that there is one that is not, and, that is, it's not the labor costs that are driving up, it's not the nurse aides, the nurses, the housekeepers, and that driving it up. It's a failure on the system's part to have any national policy with respect to where the capital development is going to be in the health care system, providing access to everyone, so that we don't have our good, large employers, like AT&T or General Motors or Ford, subsidizing those employers who are not providing any health care and, thus, becoming less competitive with foreign competition.

We have the cross of problems of unrestrained controls on various factors in delivery. I think that the system now provides, from the physician's end, I don't want to get into a war here, but I think there needs to be some review of the costs of the physicians and the charges that they provide.

There is no one solution, as we in Michigan have been working on it, nor is there just one source of the problem.

Commissioner DAVIS. I, too, enjoyed your testimony very much and appreciate you being with us. In view of your recent comments, your latest comments, I was interested in one point. You said that further cost savings can be secured only through controlling outpatient costs, and you emphasized that, reducing benefits, asking employees to pay more out-of-pocket.

Most of us in the health care field, and I think in Government and in the insurance business, have looked on outpatient services as being infinitely more cost-effective and equally of the same quality as otherwise.

As you know, 40 percent of the health dollar, 40 cents out of the health dollars goes to the hospital. This is one shiftee that we like, that we have shifted a lot of inpatient services to outpatient. This is one of the reasons that Medicare B shows up larger than Medicare A, because we have encouraged people to shift services, to accept services out of the hospital.

I was just interested why you came down on controlling outpatient costs, and maybe that's a misstatement.

Mr. POLICICCHIO. We are not coming down on controlling outpatient costs. I think we are pointing out that as we control inpatient costs and drive those down, out of necessity, outpatient costs are going to go up. That's the point that we were trying to make.

Commissioner DAVIS. Good. Just so you understand that a lot of that is shifted from inpatient services.

Mr. POLICICCHIO. Yes.

Chairman GRADISON. Thank you very much.

Mr. POLICICCHIO. Thank you.

Chairman GRADISON. Glad to have you with us.

The next panel is made up of Lynn Olman, the president of the Greater Cincinnati Hospital Council, and chairman of the Greater Cincinnati Chamber of Commerce Health Care Committee, and Sarah Grim, the president of the Greater Dayton Area Hospital Association.

Thank you.

STATEMENT OF LYNN OLMAN, PRESIDENT, GREATER CINCINNATI HOSPITAL COUNCIL AND CHAIRMAN, GREATER CINCINNATI CHAMBER OF COMMERCE HEALTH CARE COMMITTEE

Ms. OLMAN. Good morning.

Congressman Gradison, Mr. Balog, and Dr. Davis, my name is Lynn Olman. I'm president of the Greater Cincinnati Hospital Council, which represents 33 hospitals in southwest Ohio, northern Kentucky, and southeast Indiana, in their efforts to provide high-quality, cost-effective health care. I'm also chairman of the Health Care Committee of the Greater Cincinnati Chamber of Commerce. The chamber's members include more than 4,200 companies and firms in the greater Cincinnati area, and I'm speaking this morning in both capacities, and wish to thank the Pepper Commission for providing this opportunity to share our serious concerns about the problems of the uninsured population in the greater Cincinnati community.

The problem of the uninsured is one that affects businesses, large and small, as well as the general community. It is a problem that's growing, according to both national and regional data.

In 1983, there were approximately 250,000 people uninsured in the greater Cincinnati area. In 1989, it is estimated that there are approximately 262,000 people who are uninsured in our area.

In 1987, data showed that of the uninsured population, over 72 percent had some link to the work force, either directly or as a dependent of a full-time, part-time, or intermittent worker.

Caring for the uninsured has become a near crisis issue nationally, but also in our community. In 1983, the amount of uncompensated care rendered by greater Cincinnati hospitals was approximately $44.5 million, according to an annual survey conducted by the Greater Cincinnati Hospital Council. In 1988, in just 6 years, the amount of uncompensated care had soared to $88.1 million, almost double.

Since the major Government programs, including Medicare and Medicaid, do not incorporate uncompensated care costs in their payment formulas, and since Medicare and Medicaid cover approximately half of the hospitalized patients, every dollar of uncompensated hospital care means approximately a $2 cost shift to the private sector.

Now, in greater Cincinnati, we are very proud of some of the things we've been able to do to address this problem, but certainly not enough. Hamilton County has a long tradition of providing care for the medically indigent through a property tax levy that currently generates $30 million annually for University Hospital and Children's Hospital Medical Center. This $30 million is in addition to the $88 million in uncompensated care that I just mentioned. The levy certainly eases the problem somewhat in Hamilton County, but in 1988, the study that's just recently been completed, there was still an additional $55 million worth of uncompensated care provided in Hamilton County.

None of the surrounding counties have levies. Our research has shown that there are really very few communities that have tasked themselves to care for the medically needy, and we're proud of the fact that we have been able to do this for over 20 years.

The City of Cincinnati Clinic, and the Cincinnati Health Network Clinic, and a variety of other community-based programs, also provide millions of dollars worth of free ambulatory care that are not included in the $88 million, and free care rendered by area physicians is also not included in this total.

Our community is clearly alarmed by this situation. In 1987, the chamber of commerce's health care committee chose this as its major issue for the year because of its far-reaching impact on the business community, and it's been its major issue since that time.

The committee recognized that solving this problem would require a variety of solutions, that there was not a single answer that would satisfactorily address the many complex aspects of the problem. The committee, therefore, decided to focus its attention initially on the employed uninsured population. We spent the majority of 1987 gathering data, looking at what other communities were doing to address the issue, and surveying businesses and health care providers about their views on various approaches to this problem.

The data revealed, as mentioned earlier, that the majority of the uninsured population has some connection to the work force, and that the majority of employers not providing any health care benefits for their employees were small businesses.

The chamber's health care committee, therefore, appointed a joint subcommittee with representatives of the chamber's Cincin-

nati Institute for Small Enterprise, which is a small business arm, to continue to pursue solutions to this problem.

Coincidentally, the United Way Community Chest of Greater Cincinnati had been conducting its own research on this problem, and had referred the issue to its planning division. The planning division appointed a subcommittee to review the data and make recommendations.

Approximately 1 year ago we all got together. A single joint committee was formed, and a collaborative effort by the chamber, the Community Chest, and the hospital council was initiated. This joint committee embarked first on two aspects of the problem: Access to insurance and insurance product awareness.

With regard to the access issue, it was learned that cost was the primary reason given by businesses that did not provide health insurance benefits. That is fairly logical and something we expected.

Since it is not possible to purchase half of an insurance policy, businesses have been faced with an all-or-nothing dilemma. Many businesses were looking for more affordable ways to offer health care benefits. This proved fruitless for many of them.

The joint committee came up with some ideas to create something called an individual or family health care account, which would be similar to a section 125 medical spending account, but would also include a catastrophic coverage component, and I have sent a description of this proposal along with my testimony.

Under this proposal, the employer would contribute to each employee's account on a monthly basis. The employer would determine the amount deposited per employee, thus, providing predictability and control of cost for the employer, and providing control of the benefit's use to the employees.

Legislation is about to become law in the State of Ohio to fund up to five demonstration projects in the State that would test various approaches to the employed in uninsured problems. We hope that this project will be one of the ones funded. We'll have to wait until later in the summer or early fall to find out.

We were pleased that this idea caught the attention of our counterparts in the Dayton community, so we have now expanded our partnership in this project to include the hospital association, the chamber of commerce, and the United Way Agency in Dayton, now full partners in this proposed project.

The project initially will cover a 14-county area in southwest Ohio, and, as I said, we are optimistic that we will be funded by the State for an 18-month period, to try this on a demonstration basis. A recent chamber of commerce survey indicated that several hundred local businesses are interested in the product. We were very pleased at that response.

With regard to the insurance product awareness issue, data revealed that businesses needed assistance in shopping for health insurance. The smaller the business, the more help was needed, and with numerous health insurance companies abandoning the small business market, particularly, in our community, this need has become even more acute.

Consequently, the joint committee recommended that a cost comparison guide be developed to help small businesses become more prudent shoppers for health insurance. The chamber spearheaded

this project, narrowing the focus initially to traditional insurance product. Perhaps, a managed care product comparison may be undertaken at a later date if this first project is proven to be useful.

In order to create what I would consider a level playing field, the chamber used the basic benefit package that was developed by the Health Policy Agenda for the American People, a national coalition of health provider and consumer group, and developed demographic profiles for four fictitious businesses. All companies offering traditional health insurance in greater Cincinnati were then given an opportunity to provide quotes based on these factors; 10 companies did respond, and the results are being published by the chamber and will be made available to the business community later this month.

On the managed care side, the hospital council has made available a booklet containing summary data on all HMO's operating in the tristate region. The booklet contains annual financial data, as well as enrollment and utilization data, which should be helpful to managers of human resources and others throughout the community.

There are a number of other efforts underway in this region to address the problem, most notably, public information campaigns to educate the community about the seriousness of this problem and its long- and short-range impact on the health care delivery system.

Another aspect of the uninsured problem that we have not yet addressed collectively, but consider to be a serious and rapidly escalating problem, is the group of uninsurables, people who are rejected through medical underwriting because of preexisting conditions. Obviously, these people, in particular, need health insurance. Here, a significant part of the problem is access as well as cost.

In greater Cincinnati, we recognize that the Federal budget deficit has severely restricted the ability to resolve some of these issues at the national level, and we also know, with working through our State legislators, and in greater Cincinnati we really have a tristate region here, Ohio, Kentucky, and Indiana, we know that the State budgets are not in a favorable position to withstand the total diversion of this problem onto the State resources either.

Without question, local communities will have to be actively involved. We've come to the conclusion, though, that we cannot do it alone. None of us can do it alone. Commitments have to be made at all levels of government, and by the private sector as well, to craft solutions that are practical, economically viable, and fair. We wish there was one silver bullet, but we know there is not.

Locally, we are working hard to address those aspects of the problem that are within our reach. We look forward to working with the Pepper Commission and others to find meaningful answers to this complex problem.

Thank you for this opportunity to testify. We salute the Pepper Commission for its indepth investigation of this very important issue.

[The prepared statement of Ms. Olman follows:]

Testimony before the U.S. Bipartisan Commission on Comprehensive Health Care
Wednesday, July 5, 1989

Members of the Commission, my name is Lynn Olman, President of the Greater Cincinnati Hospital Council, which represents 33 hospitals in Southwest Ohio, Northern Kentucky, and Southeast Indiana. I am also Chairman of the Health Care Committee of the Greater Cincinnati Chamber of Commerce. The Chamber's members include more than 4,200 companies and firms in the Greater Cincinnati area. I am speaking this morning in both capacities, and wish to thank the Commission for providing this opportunity to share our serious concerns about the problems of the uninsured population in the Greater Cincinnati community.

The problem of the uninsured is one that affects businesses --large and small-- as well as the general community. It is a problem that is growing, according to both national and regional data. In 1983, there were approximately 250,000 people uninsured in Greater Cincinnati; in 1989 it is estimated that there are approximately 262,000 people who are uninsured in our area. In 1987, data showed that of the uninsured population, over 72% had some link to the workforce, either directly or as a dependent of a full, part-time, or intermittent worker.

Caring for the uninsured has become a near-crisis issue. In 1983, the amount of uncompensated care rendered by Greater Cincinnati hospitals was approximately $44.5 million, according to an annual survey conducted by the Greater Cincinnati Hospital Council. In 1988, the amount of uncompensated care soared to $88.1 million, almost double in just six years. Since the major government programs --Medicare and Medicaid-- do not incorporate any uncompensated care costs in their payment systems, and since Medicare and Medicaid cover approximately 50% of hospitalized patients, every dollar of uncompensated care means a $2 cost shift to the private sector.

Hamilton County has a long tradition of providing care for the medically indigent through a property tax levy that currently generates $30 million annually for University Hospital and Children's Hospital Medical Center. This $30 million is in addition to the $88 million in uncompensated care. The levy certainly eases the problem somewhat in Hamilton County, but in 1988, there was still an additional $55 million in uncompensated care provided in Hamilton County. None of the surrounding counties have levies. Our research has shown that there are very few communities that have taxed themselves to care for the medically needy. The city of Cincinnati clinics and the Cincinnati Health Network clinics also provide millions of dollars worth of free ambulatory care that are not included in the $88 million.

Our community is clearly alarmed by this situation. In 1987, the Chamber's Health Care Committee chose this as its major issue for the year because of its far-reaching impact on the business community. The Committee recognized that solving this problem would require a variety of solutions; that there was not a single answer that could satisfactorily address the many complex aspects of the problem. The Committee therefore decided to focus its attention initially on the employed uninsured population. The Committee spent the majority of 1987 gathering data, looking at what other communities were doing to address this issue, and surveying businesses and health care providers about their views on various approaches.

The data revealed, as mentioned earlier, that the majority of the uninsured population had some connection to the work force and that the majority of employers not providing any health care benefits for their employees were small businesses. The Chamber's Health Care Committee therefore appointed a joint subcommittee with representatives of the Chamber's Cincinnati Institute for Small Enterprise to continue to pursue solutions

to this problem. Coincidentally, the United Way/Community Chest of Greater Cincinnati had been conducting its own research on this problem and had referred the issue to its Planning Division. The Planning Division appointed a subcommittee to review the data and make recommendations.

Approximately 1 year ago, a single joint committee was formed and a collaborative effort by the Chamber, the Community Chest, and the Hospital Council was initiated. This Joint Committee embarked first on two aspects of the problem: access to insurance and insurance product awareness.

With regard to the access issue, it was learned that cost was the primary reason given by businesses that did not provide health insurance benefits. Since it is not possible to purchase half of an insurance policy, businesses have been faced with an "all or nothing" dilemma. Many businesses were looking for more affordable ways to offer health benefits. The Joint Committee came up with an idea to create Individual or Family Health Care Accounts, which would be similar to Section 125 medical spending accounts, but would also include a catastrophic coverage component. (A description of this proposal is appended to this testimony.) Under this proposal, the employer would contribute to each employee's account on a monthly basis. The employer would determine the amount deposited per employee, thus providing predictability and control of cost for the employer and providing control of the benefit's use to the employee. Legislation is pending in the Ohio legislature to fund up to 5 demonstration projects in the State that would test various approaches to the "employed uninsured" problem. The project caught the attention of the business community in Dayton, Ohio, so we have now expanded our partnership to include the Hospital Association, Chamber of Commerce, and the United Way agency in Dayton. The proposed project will initially cover a 14-county area in Southwest Ohio. We are optimistic that the Individual/Family Health

Care Account project will be among those funded for an 18 month period, and hopeful that it will offer an affordable means of extending benefits to more people through the workplace. A recent Chamber of Commerce survey indicated that several hundred local businesses are interested in the product.

With regard to the insurance product awareness issue, data revealed that businesses needed assistance in "shopping" for health insurance. The smaller the business, the more help was needed. With numerous health insurance companies abandoning the small business market, this need has become even more acute.

Consequently, the Joint Committee recommended that a cost comparison guide be developed to help small businesses become more prudent shoppers for health insurance. The Chamber spearheaded this project, narrowing the focus initially to traditional insurance products -- a managed care product comparison may be undertaken at a later date. In order to create a "level playing field," the Chamber used the "Basic Benefit Package" developed by the Health Policy Agenda for the American People (a national coalition of health care provider and consumer groups) and developed demographic profiles for 4 fictitious businesses. All companies offering traditional health insurance in Greater Cincinnati were then given an opportunity to provide quotes based on these factors. The results are being published by the Chamber and will be available to the business community later this month.

On the managed care side, the Hospital Council has made available a booklet containing summary data on all HMOs operating in the tri-state region. The booklet contains annual financial data, as well as enrollment and utilization data, which should be helpful to managers of human resources and others throughout the community.

There are a number of other efforts underway in this region to address the problem, most notably public information campaigns to educate the community about the seriousness of this problem and its long and short range impact on the health care delivery system.

Another aspect of the uninsured problem that we have not yet addressed collectively but consider to be a serious and rapidly escalating problem is the group of "uninsureables" -- people who are rejected through medical underwriting because of pre-existing conditions. Obviously, these people, in particular, need health insurance. Here a significant part of the problem is access as well as cost.

We recognize that the federal budget deficit has severely restricted the ability to resolve some of these issues at the national level. Similarly, most state budgets are not in a more favorable position and cannot withstand diversion of a sufficient amount of resources to resolve these issues either. Without question, local communities will have to be actively involved. We have come to the conclusion, though, that we cannot do it alone --commitments must be made at all levels of government and by the private sector to craft solutions that are practical, economically viable, and fair.

Locally, we are working hard to address those aspects of the problem that are within our reach. We look forward to working with the Pepper Commission and others to find meaningful answers to this complex problem.

Thank you for the opportunity to testify. We salute the Commission for its indepth investigation of this important public issue.

Chairman GRADISON. Thank you.

Ms. Grim?

Ms. GRIM. I do have testimony I gave to your staff. I hope that they have given it to you so you can follow.

Chairman GRADISON. We have seen that.

Ms. GRIM. It's in red folders, there's about 20 of them.

Chairman GRADISON. Well, why don't you go ahead, and we'll catch up with you.

STATEMENT OF SARAH GRIM, PRESIDENT, GREATER DAYTON AREA HOSPITAL ASSOCIATION

Ms. GRIM. OK, thank you.

My name is Sarah Grim. I'm president of the Greater Dayton Area Hospital Association [GDAHA], and I appreciate the opportunity to speak with you today.

I did want to concur with what Lynn Olman said about the Greater Dayton Area Hospital Association and the United Way and the chamber of commerce being a partner with their demonstration project. We are very excited, and we are looking forward to having an opportunity to implement that in our service area, as well as to see what the results are in Cincinnati.

However, I'm here today to talk about long-term care, and I hope that with my testimony I'll be able to bring some insight into what I see is a natural bridge between what's happening in the hospital and what's happening in the long-term care community.

My testimony will focus upon subacute care, as one component of a long-term care continuum, and I appreciate the Bipartisan Commission looking at comprehensive health care because I think that's one of the critical needs of the populations in the country today.

My intent is to provide the members of the Commission with information about one program that can address part of the problem of access to long-term care, and, perhaps, provide a cost-effective means of doing so.

The advent of the Medicare Prospective Payment System has created a new category of patient, one that remains in the Nation's hospitals at a cost to the provider, to the Federal and the State governments, and to the patient himself. This new patient is a subacute care patient. This patient is a patient with extraordinarily high acuity levels, who requires less care than that provided normally in an acute care setting, but more care than that typically provided in a nursing home.

Subacute care has been defined by the Prospective Payment Assessment Commission [PROPAC] as care provided to patients who do not need established criteria for medically necessary acute care. This patient has also been called a super skilled nursing care patient.

According to the American Hospital Association, hospitals across the country provide over 500,000 to 700,000 days of care to subacute care patients. In 1988, PROPAC found that 55 percent of all subacute care patients in hospitals were awaiting nursing home placements.

On an average day in six GDAHA member hospitals, there are over 70 patients awaiting placement in area nursing homes, and on most of those days we go out to the service area of over 100 miles away from Dayton to find placement for these patients.

Because subacute care is not an accepted level of care or a benefit to the Medicare population for payment purposes, reimbursement and access to subacute care is very limited in this country right now. The lack of recognition by both Medicare and Medicaid of the subacute care patient creates a particular problem for providers and for patients. Currently, the subacute care patient stays in the hospital setting, awaiting placement in a nursing home, from 1 day to over 1 year or more, and that is dependent upon the patient's care requirements, the availability of certified nursing home beds, the level and expertise of nursing home staff, and a family's ability to pay for the patient in a long-term setting.

Nursing homes are typically loath to accept the patients due to problems with reimbursement, with staffing, and with the patient care requirements.

For the patient and their family, a major problem is trying to find alternative sites for placement from the hospital. Nursing home placements are generally the least acceptable for both patients and families for obvious reasons. According to most estimates, between 25 percent to 40 percent of institutionalized persons are placed in nursing homes due to a lack of alternative care services.

In Ohio, the Governor's commission recently found that 18 percent to 22 percent of all patients placed in nursing homes in Ohio could have been placed elsewhere if there had been alternative care available.

Over 62 percent of these institutionalized patients are admitted directly from a hospital. The average length of stay in a nursing home is 2 years, and once entered a patient usually dies there.

I want to give you a perspective of what has changed with the advent of the prospective payment. In 1965, Medicare established a Hospital Payment Program, a Physician Payment Program, and something called Extended Care. The Extended Care Benefit, which became quickly known as the Skilled Nursing Care Benefit, basically provided 100 days of care in a skilled nursing facility per spell of illness. There was a 3-day prior hospital stay required. It established criteria for what skilled meant, in order to be admitted. There was no length of stay requirement on where that patient could stay, or how long the patient could stay in extended care, but it had to be in a certified extended care bed by the Medicare Program. It did set standards for Medicaid and private insurance, and I think that's an important point, because as you've heard today, Medicare is a standard for what happens in the other parts of the insurance industry. So, what Medicare said was skilled nursing care in 1965 became skilled nursing care for Medicare, and, today, becomes skilled nursing care for other of the payers.

The impact of the Extended Care Program in 1965 was pretty limited. Hospital stays used to be much longer, as we all know, and, therefore, there was very little need for what then was the Extended Care Program, but there have been extensive changes in 1989.

What have been those changes? Prospective payment has shortened length of stay in hospitals, therefore, putting undue incentives on hospitals, physicians, and patients to get that patient out of the hospital. At the same time the shortened length of stay went into effect, the number of extended care providers certified by the Medicare Program went down, so you've got an increasing demand and a decreasing supply.

The Federal Government also implemented Certificate of Need Programs in health planning, which, again, limited the number of available extended care beds and facilities. They imposed cost limits upon nursing homes, therefore, discouraging nursing homes from taking a more costly patient. They implemented the Peer Review Organization Program, which started looking at what skilled criteria was, and, basically, the impact has been to, again, limit the length of stay and access to the skilled benefit under the Medicare Program.

Catastrophic health care came along in 1988, and I do commend Members of Congress for implementing and approving that program, but I see it as an empty benefit when it comes to extended care, because, basically, you are looking at a program no one has access to, and then what you did was, you went from 100 days of coverage to 150 days of coverage. The average Medicare beneficiary, if they are lucky, gets less than 30 days of coverage under the Extended Care Program.

They also eliminated the 3-day prior hospital stay, in an effort to increase access to those services and, yet, limited the number of available providers. They eliminated the spell of illness, again, trying to increase access, but there are no providers. They did nothing to redefine what skilled care was in 1988 or 1989, and they did nothing to look at the length of stay and utilization review requirements that are being imposed by the PRO's or by the Medicare fiscal intermediaries.

Basically, what we see in 1989 is a patient that is subacute, that is not basically eligible for any programs, either Medicare or the Medicaid Programs nationally, and that patient is basically being dumped either in the hospital or dumped inappropriately into a nursing home setting.

In order to get to a solution, I think you are looking at solutions, I think you have a good opportunity now to look at what has been the result of the Rural Swing Bed Program. This program was established in 1980, to allow small rural hospitals to provide three levels of care to these kinds of patients without transferring the patient out, and without making the adjustment internally to establish a nursing home in the hospital setting.

The results of this demonstration program established by HCFA [Health Care Financing Administration] and established by Congress are out, and I have given you the details, the experience, which show a great impact on patient outcomes, because the No. 1 outcome has been that patients go home more frequently from a swing bed setting than they do from a nursing home, and I think that's an important, very, very important outcome. This program was expanded in 1987 to hospitals with 99 beds or less, again, your rural hospitals only.

I'd like to close with a recommendation for the Commission's consideration. I would like to see the Rural Swing Bed Program expanded nationally to all hospitals. I would like to see the Commission recommend that what the Medicare Program needs to do with Skilled Nursing Care and its Extended Care Program is to redefine it, in light of what medical practice is, and what medical diagnosis is these days.

I would like to see a new benefit replace the Extended Care Program, and call it Subacute Care, and make that benefit available to the Medicare population in lieu of nursing home placements.

And, I think last, I think the Commission may want to consider looking at access to these kinds of services and, perhaps, making the extended care or subacute care benefit directed at the Medicare beneficiaries, and let the beneficiary get the service where they want it. They can't get it in a hospital if the hospital is not certified, they don't want to go to a nursing home unless they absolutely have to, and by providing this benefit directly to them they could, perhaps, reimburse a hospital for getting that service in the hospital setting.

So, with that, I'll close because I know my time is up, but I have had experience with a Swing Bed Program. I do know subacute care when I see it, and I think it's a great need in this country right now to address it.

Thank you very much.

Chairman GRADISON. Thanks to you, thanks to you both.

Ms. Olman, I wanted to make sure I understood what you meant when you said, and I quote: "Since it is not possible to purchase half an insurance policy, businesses have been faced with an all-or-nothing dilemma." Are you referring to the ERISA situation where a State mandates?

Ms. OLMAN. No.

Chairman GRADISON. I mean, the reason I ask, I don't mean to be dense but, you know, one can provide half an insurance policy by saying that the company will pay half and the employee, if they wish to participate, can pay half. So, I just wondered what you meant by this.

Ms. OLMAN. I didn't mean that. What I meant was that we have some employers who said, well, you know, maybe I could afford $75 or $100 a month per employee, but a decent health insurance program is now $250 or $300 per employee per month, and, you know, we know that the employees can't pick up half of a policy, for example, and so we're left with either not providing anything at all or something that they can't afford.

So, we're hoping that the product that we have developed, that we hope to demonstrate through this project, will appeal to those employers who really want to do something for their employees but, perhaps, something financially less expensive than purchase of a full health insurance.

Chairman GRADISON. Have you examined what a number of small businesses have been doing in Cleveland?

Ms. OLMAN. Yes, a very impressive program in Cleveland that the chamber's health care committee has looked at. I only mentioned two of the efforts of the committee because there were about six or seven on the initial list, and a Cleveland-type product is one

that we looked at that is not fully developed enough for our committee yet to make any recommendations. So, we still have four or five different topics on our list that we have not developed recommendations to bring to you today, but that is certainly one that has worked very well, and we've been impressed with what they've been able to accomplish.

Chairman GRADISON. Mr. Balog?

Commissioner BALOG. One question, again, a technical one. In this Family Health Care Account Program that you have, are those setasides, those amounts that are put in by the employers, are they tax deductible? Have you looked into that?

Ms. OLMAN. Yes, they are.

Commissioner BALOG. Most of the time, prospective payments like that are not. Did you get a special dispensation from the Internal Revenue Service?

Ms. OLMAN. This would operate similar to a 125 plan, and the big difficulty with this type of program, one which we are trying to address in a variety of different ways, is the fact that the regulations currently prohibit the money from rolling over from 1 year to the next and, therefore, it makes it very difficult for an employee to sort of keep the money in the bank, or the employer to keep the money in the bank. And, there are a variety of ways that we hope to get around that. It would be much easier if we could get some change in the tax law, but that's always an up-hill fight. But, it would be pretaxed, as it would be to a 125 point of view.

Commissioner BALOG. And, Ms. Grim, the question I have for you is, what is the cost difference between a subacute care patient and an acute care patient? In other words, what is the saving on those 500,000 to 700,000 patient-days?

Ms. GRIM. Because there is no such thing in the Medicare Program as a subacute care patient, I think it's very difficult to say what the cost of that patient is to the Medicare Program.

What we look at, from the programs that have done swing beds, for example, or are providing high level skilled care, super skilled care, the average cost is less than $300 a day. What you see in some of the hospitals where these patients are staying is an average cost of $580 per day and over, and those are very real costs because they are being tracked.

But, what we think we can provide to this patient in a different setting, even the same bed, would be about $300 a day.

Commissioner BALOG. About half.

Ms. GRIM. Half.

Commissioner BALOG. OK, thank you.

Chairman GRADISON. Dr. Davis?

Commissioner DAVIS. Ms. Olman, I commend you on what you are doing in this community to address your health problems at the local level and, certainly, as you say, we can't solve this at the local level alone, but I think what you are doing here will serve, and should serve, as a role model, as a model for so many other communities to come together, evaluate their problems, and go for a solution, and I commend you on that very much.

Also, I appreciate you dropping in what the hospital give in free care, and what physicians give in free care, and there's good data to support the fact that on average physicians in this country con-

tribute $28,000 worth of free care to our health care system every year. Harassed and regulated as we are, physicians still contribute $28,000 in free service. I appreciate you bringing that up. You are doing great work here.

Ms. OLMAN. Thank you.

Commissioner DAVIS. Ms. Grim, I'm intrigued by your swing bed concept, being transferred, expanded from rural hospitals to all hospitals, and I like very much your term "subacute care." I think that's one that we really ought to look at and recommend going to. It's so much more accurate, appropriate, and usable than skilled nursing and things that people really don't understand.

Let me ask you a naive question. Economically, how feasible is it for other hospitals to establish swing beds, say, a large hospital of 500 to 600 beds already, with a new bed wing to use in the swing capacity, sometimes for acute care, sometimes for subacute? Economically, is that feasible for a board of trustees to consider?

Ms. GRIM. I think economically it is feasible, and one of the things that the Greater Dayton Area Hospital Association has done in the last several months is to develop a model to actually do a demonstration along these lines.

Commissioner DAVIS. Who did that?

Ms. GRIM. Pardon?

Commissioner DAVIS. You did that in Dayton?

Ms. GRIM. We have not done it yet. We are hoping to get some interest on the part of Congress or HCFA to actually do a demonstration, because we've found that HCFA relies heavily on demonstrations before they make recommendations to Congress to expand a program.

Part of the answer to your question of how economically feasible is it to allocate new beds or new wings is that, in spite of what we would like to see in a hospital setting, which is not really very significant, we'd like high occupancy, we are not, and we have excess beds, and I think it's a more cost-effective use of those beds to put them into a swing bed program than to build new nursing homes, because, again, our interest is putting the patient back home, and not warehousing the patient in a long-term care facility.

Commissioner DAVIS. That's certainly true, and that's why the rural hospitals were chosen, because they had available beds.

Ms. GRIM. Right.

Commissioner DAVIS. But, you are right, the census is down in most areas, but the many areas who would be interested in this would have to build new wings, that's why I asked.

Ms. GRIM. I think part of the answer to that as well, if you look at what's going on in New York City, for example, with AIDS patients, is, those hospitals are keeping those patients anyway, and I think what you would be able to provide with those patients or with a subacute care patient, that the hospital is keeping now, they are not being discharged, is that they would be able to better manage that patient's care in the same setting and, perhaps, there are hospitals in the communities without the high census that some of the hospitals in New York City have that could become, then, feeder hospitals for this kind of a patient.

Commissioner DAVIS. Thank you.

Chairman GRADISON. This is not unrelated to the special problem of rural hospitals, which have been particularly hard hit by changes in recent years, and especially by the drop in the occupancy rates, especially the little ones that are 25 beds or less. We are seeing a lot of them closing, a lot of them questioning their future role.

And, one of the things that we are recommending from our Ways and Means Health Subcommittee is some experimentation on a voluntary basis in up to 10 States with the idea of some of these institutions, which are remote and small, playing a very different role than they have in the past. They might not even be called hospitals, but their role might be to stabilize the patient until the patient can then be moved to a facility which offers a broader range of care.

We found a great deal of interest among our colleagues, in both the House and the Senate, in the special problems of rural hospitals, not to the exclusion of others, but their problems are somewhat different, and the swing bed concept is part of that.

But, I just wanted to mention that we are looking into this rather broadly. Most of the 80-odd hospitals that closed last year were rural hospitals, and these seem, according to statistics, to be under particular stress financially.

Well, thank you very much.

Ms. GRIM. Thank you.

Chairman GRADISON. Our next panel is made up of Mrs. Barbara Dick, Joe Sieber, and Mr. and Mrs. Jeff Rigg.

Mrs. Dick, would you care to go first? Perhaps, we can assist you with the microphone so that others can hear you. Thank you.

STATEMENT OF BARBARA DICK, CINCINNATI, OH

Mrs. DICK. Good morning, gentlemen.

My name is Barbara Dick, and I am from Cincinnati. I am 64 years old. My husband, Bill, and I are the parents of six grown daughters.

I am here today to tell you about our families experiences in coping of the costs of my catastrophic illness.

Ten years ago, when I was 54, I had the world by the tail. I had spent the last 24 years raising our six beautiful daughters, and led a busy, happy, and active life. I bowled, organized wedding receptions at my church, was a Campfire Girl and Girl Scout leader, in addition to doing the gardening. Bill was in the construction business. Two of our daughters were still at home then, the youngest, 14, and the other a freshman in high school.

Our world changed when doctors discovered a tumor in my spinal cord—6 months later, I was a quadriplegic. I am paralyzed from the neck down, except for a little mobility in my left hand and arm. My family must assist me in all of my daily activities. They have to bathe and dress me and do my hair. My husband cooks dinner and does the laundry. And, thank God for microwave ovens and frozen dinners. Bill does not know how to cook, and he says he's too old to learn.

Until 2 years ago when I got my electric wheelchair, my family had to move me constantly. A home health aide helped me with

my morning activities and arm therapy. Bill comes home at lunch to do my afternoon therapy.

When the tumor was first diagnosed, I was only given 6 months to live. I'm thankful that I've lived this long, and that I have a loving family to help me.

The only thing that really bothers me about all this is the lack of support from the Government. Without any Federal assistance, our family had to go in debt to cover our medical expenses. Blue Cross and Blue Shield did pay all the hospital costs, but very little of the doctors' fees. As a result, we had to pay thousands of dollars out-of-pocket which drained our old age savings. Our financial difficulties were compounded by the fact that at that time interest rates were high and construction business was poor. Consequently, no pay check. It took us 6 years to get out of debt. We didn't pay our property taxes for 5 years, but we have worked out of that situation.

Since I have worked from the time I was 17 to age 30, social work and some doctors told me I qualified for disability, but when I applied, Social Security said I was not eligible. The rules state that you had to have worked 5 years out of the 10 years prior to the disability. And, I just couldn't understand it, because we all know people that have never worked that are receiving disability.

A couple years later, the doctors and social workers said I would be eligible for Medicare. Once again, no, you can only get Medicare before age 65 if you have been on disability for 2 years.

We consulted a lawyer, and he agreed that that's the way the laws were. They said if Bill and I got a divorce, put everything in Bill's name, I could qualify for welfare and Medicaid. Well, we didn't do that because we honor our marriage vows.

Currently, our family spends $8,000 a year for my medications and home health aide and repairs on the wheelchair. Bill is 70 and still works part time in order to pay our expenses.

Last year, we faced another scare. I was having trouble breathing, and the doctors thought I had lung cancer. Luckily, they found no evidence of this. However, there we were with more bills to pay. My situation will not change for the rest of my life, and we are barely getting by financially right now. I don't know what would happen if my condition worsened, or if something happened to Bill. We can't afford more health care.

The system just doesn't seem fair. There should be help available for families in catastrophic situations, and I would just like to have one more thing, I hope that Congress doesn't mess with Medicare, because I'm eligible for it in 13 more months.

Chairman GRADISON. Mr. Sieber?

STATEMENT OF JOE SIEBER, CINCINNATI, OH

Mr. SIEBER. Good morning. My name is Joe Sieber. I live in rural Cincinnati, about 40 miles from downtown. My wife and I have been married for 56 years.

Can you hear me?

Chairman GRADISON. Yes, fine, Mr. Sieber, thank you.

Mr. SIEBER. Like most married couples, we have had our share of wonderful times mixed with the bad, but we have always been able to take care of ourselves.

I am 78 years old, and my wife will be 78 this November. I retired at age 65. Before retiring, I was an advertising artist for a large Cincinnati corporation. My wife and I have five children. The youngest is now 37 and the oldest is 55.

It is our middle son, Robert, that I want to talk to you about. Robert is 46, and was born profoundly retarded. That means Robert cannot talk, and he needs assistance in doing just about everything. He needs help in going to the bathroom. He needs to be washed and bathed. He needs to be shaved. He even has to have his hair combed. He cannot climb stairs on his own. He cannot manage a knife and fork, so he eats with his fingers. Because of this, his food needs to be cut into small pieces so he won't choke.

About the only thing he can do is walk. If that is not bad enough, over the past few years he has developed Venes, that's V-e-n-e-s, Venes disease, which requires that his legs be washed and bandaged daily. We have to check his legs to be sure no sores are developing. We have been doing a pretty good job, because right now Robert has no sores on his legs. The ointment and bandages we have to get for Robert are expensive, about $125 a month, and that is with me buying the bandages in bulk quantity to get a discount.

Medicare does not cover 1 cent of this expense, because these items are disposable, neither does Blue Cross or Blue Shield. The only help we get is from a home health aide who comes to our home for about an hour twice a week to help my wife, Beth.

Things were going OK for us until this past year. Last summer, because of my circulatory problems, I had to have my left leg amputated. At the same time, my wife had a heart attack and was in the hospital. Well, I was really up a tree trying to find someone to help with my son.

The other children are grown, married with children of their own, and working. In fact, one of my sons lives in New Mexico, so he could not take much time off to help. The kids did what they could. The Clermont County Council for the Mentally Retarded put together some crisis volunteers and workers, but the council had no real permanent solution.

I have been told that the residential facilities for the mentally retarded are completely filled. In fact, in these institutions, they have waiting lists. If I put Robert on a waiting list, I was told he would be No. 401, and who knows if he would ever be called.

But, with the help of the council and our neighbors, we were able to get over last summer's crisis, just in time for me to have a heart attack in November. I'm still having circulatory problems, and I was back in the hospital in June.

All of this brings me to two concerns. First, what is the present and future going to be like for Robert? There is no place for him to go now. How can I rest easy at night knowing that if my wife or I get sick again, he may be alone without help?

Second is, how are we going to pay for his care? I have thought that a nursing home would be OK for Robert, but at $22,000 to $25,000 a year, I cannot afford it. My Social Security is $1,000, and my pension is another $600. That totals $1,600 a month. To some, it might seem like a lot of money, but when you consider the increasing utility bills, my wife's and my medical expenses, insurance,

clothing, Robert's expenses, the increasing tax, and other bills, that really does not leave a lot for food.

Most people are moving to our part of the county, and with the encroachment of the suburbs our real estate tax is also growing. In fact, our real estate tax just about doubled recently. We are far enough out from downtown in the country that there are no gas lines, so we live in a total electric home, and we all know how electricity prices have been rising.

There is no way we can afford to put Robert in a nursing home, and since Robert is not medically sick he does not qualify to have Medicaid to foot his nursing home bill.

We have spent a lifetime providing for our son, taking care of him, loving him, and wanting the best for him, as we do for all of our children.

After 46 years, I should think that the Government could do better than two 1-hour visits from an aide. Now we need your help, and I guess there's no help to get. We will do the best we can.

You know, if we had placed Robert in an institution when he was born, it would have cost the State thousands of dollars to take care of him, but we wanted him to live with us. We supported him. We saved the State probably $1 million, and now no one will help us.

I hope your Commission will see a way to help folks like me. Thank you.

Chairman GRADISON. Mrs. Rigg?

STATEMENT OF DEBORAH RIGG, AMELIA, OH

Mrs. RIGG. Good morning. My name is Deborah Rigg. I'm from Amelia, OH. I'd like to start off by saying that my problem is no where near being unique, there are many people out there like us.

I am presently full-time employed, and so is my husband, Jeff, and we have a 17-year-old boy.

Mr. RIGG. Seventeen months.

Mrs. RIGG. Seventeen months, sorry. I'm a little nervous here. And, we have another one on the way in about 3 months.

Recently, I discovered that there is no prenatal care available for people without insurance. I have tried every hospital, clinics, you name it, the downpayment to start my care was anywhere between $400 and $800. Private doctors were even worse.

I recently had an injury at work, for which I was sent to the hospital to be checked because of my pregnancy, and one of the doctors there called in a favor, and I did eventually get help.

In the meantime, we are considered below the poverty level, and there is no insurance. It's really expensive. I'm really nervous, too. It's really expensive to have a baby, and a lot of people say that there are ways of preventing it. Yes, there are, but not all of them are sure.

I am presently being seen by the Batavia Family Health Center. We get a discount because we are low income, but a lot of the expenses are out of our pocket.

The employer that I had up until 3 months ago offered insurance, but the insurance was outrageous. My income was $137 a week. Their insurance was $69 a week, and it only covered 60 percent of our medical expenses.

My husband's company doesn't give him any insurance at all, or what they do offer there's no way we can afford it. Not only are we having difficulties finding prenatal care, but the care for our 17-month-old is also just as expensive. Immunization shots are anywhere between $15 and $40, and the doctor's visits itself runs about $45 average. Therefore, he is also behind in shots.

I am not proud to admit that, but we do the best we can do. There are programs out there for people who want to lay back on welfare. You can get all the help you want, but people who are out there working hard and trying to make it, there is not an ounce of help for us.

I was told to contact the welfare office, they have a new program called the Healthy Start Program. This program allows a family of 4 to make $941 a month. We missed that by about $50, and we were denied help. I was also denied help from over half or more of the O.B. clinics in the Clermont and Hamilton County area because I was not on welfare. I was told that if I quit my job I would qualify for the Healthy Start Program. I was also told that if I was to leave my husband, welfare would take care of me, my son, and my newborn. This is no way to go to get health care. We have no intentions of doing this, but there's got to be a better way for middle class people to make it.

We are considered to be below income, below the poverty level, and, yet, we can't even get help from anybody, there's no help out there for us. We don't know where to go.

At the present time, as I stated, I am getting help from the Batavia Family Health Center, and I am on a payment program. And, in about 5 days I will find out if my insurance from my new job will pick up the payments for the newborn. If not, we are again faced with the dilemma of paying increased monthly payments and a big hospital bill for the delivery of our newborn.

The only way to avoid these expenses is to go all 9 months without care, walk into University Hospital and say, guys, I'm in labor, somebody deliver my baby. I was told that that was one way to get my baby delivered at low cost.

On the other hand, I can travel all the way to Kentucky to St. Elizabeth's Hospital, and they do have a clinic for low-income people, and get my prenatal care. I think it's kind of sad that someone from Ohio has to go all the way to another State to get prenatal care. There's got to be a better way for people like us to get help, and there are so many more out there that are like us.

Mr. RIGG. This isn't the first time we've gone through it. With our first son, we had to take out a loan for the downpayment to a clinic, we had to increase the loan to keep up with the payments and buy furniture and all the necessities the baby needs, and we still owe the doctors and the hospitals for the first baby. We haven't been able to pay them. It's really quite sad.

Mrs. RIGG. We just wonder what would happen if one of us had to go off work. My 6 weeks is going to almost kill us, to be off for prenatal care, or for my 6 weeks recovery.

Mr. RIGG. Thank you very much.

Chairman GRADISON. Thank you. Thank you all. Mrs. Rigg, I think you summarized better than anything we have heard today why this Commission was created, when you said: "There's got to

be a better way." That's what we are looking for, and the very fact that you all are willing to come down here is an indication of, not only your concern, but your willingness to help us seek a solution. We are awfully glad to be here. You've done a great job in sharing with us what it's really like out there.

Questions?

Commissioner BALOG. No.

Commissioner DAVIS. No, I don't think so, except to thank all of you for coming in and sharing your experiences with us.

I happen to practice medicine in North Carolina, and so I know what you tell us can be replicated many, many times by other people, and, as the Chairman said, that's why we have this Commission, that's why we're giving the time to serve on it.

Mrs. Rigg, as I'm sure you won't, but do not forego prenatal care whether you ever pay for it or not. Go get it, and don't present for the first time at the time of your delivery, and I'm sure you won't. That's really the cause, as most of you know, of our infant mortality and morbidity problem, is the absence of proper prenatal care. I wish you well, and do get under care, accept it whether you ever pay for it or not.

Mr. RIGG. Well, Mr. Davis, believe it or not, an O.B.'s wife told us to do that.

Commissioner DAVIS. What?

Mr. RIGG. An O.B.'s wife told us to wait 9 months and deliver in the emergency room.

Commissioner DAVIS. I will not ask you who that was, and please don't tell me.

Chairman GRADISON. Thank you very much to all of you for being with us. We certainly appreciate it.

Our next panel is made up of Dr. Stanley Broadnax, commissioner of health, city of Cincinnati, Dr. Judy Daniels, the director of the Cincinnati Health Services Network, and Steve Wilhide, who heads the Southern Ohio Health Services Network.

Dr. Broadnax, will you lead off, please?

STATEMENT OF DR. STANLEY E. BROADNAX, COMMISSIONER, CINCINNATI DEPARTMENT OF HEALTH

Dr. BROADNAX. Yes, sir.

Congressman Gradison, Mr. Balog, and Dr. Davis, welcome to Cincinnati. It's a pleasure to have you here. I only have 5 minutes, and I will provide an overview of the problem to this panel and then turn it over to my colleagues.

Let me just say that I am a physician, as well as an administrator. I have an M.D. and also an M.P.H. in administration, and I'm also an entrepreneur, so I'm a small business person.

As an entrepreneur, I get somewhat disturbed when we refer to small businesses as companies that's under 5,000 people. There are those of us who are out there who are under 10, 15, and 20 employees, many doctors' offices fit into those categories also, but we are often overlooked when we talk about statistics relating to small business.

So I'm speaking from a perspective of a physician, a public health administrator, and as a small business person.

I was struck by the previous testimony in which it was stated that: "There must be a better way" for us to deliver health care. While we are addressing specific concerns of the uninsured indigent, we really cannot address just this part of the system without looking at our total system. In approaching this particular subject, we are talking about our Nation's security. Health is just as important to our national security as building our weapons systems.

We are talking about commercial industry; and we are talking about our armies. We know when we look at our trade deficits, we are competing with foreign companies. When we look at our armies, we know we are competing internationally. Unless our populous is healthy, our children cannot learn in school, our army trainees cannot be trained, our industrial technicians, not necessarily the engineers, but the technicians, cannot be trained. There must be basic health care for that large populous if America is to remain competitive in the international politico-economy.

From the uninsured indigent population will come our soldiers to man our armies. From that population will come the employees who will be our technicians, who will provide the basis for many of our industries.

In so much as this population is growing and our health care system is not meeting their health needs. Do we have the solutions? I can tell you how to solve this problem. There is enough information in HCFA, there are enough pilot projects that have looked at how we can contain costs, save resources, and control utilization. The problem has been that we as a country have not had the resolve to bite the bullet, to make the necessary systemic changes.

In the process of developing solutions the first thing that gets talked about is, how much it's going to cost, and who is going to pay the cost. We are currently spending enough on health care in this country to cover all of those costs. You've heard information just right here in Hamilton County where the hospitals are providing in uncompensated care $88 million. There's a tax levy that is providing $30 million to the University Hospital and to Children's Hospital. The health department, in conjunction with the network, runs a network of 12 neighborhood health centers.

The city government subsidizes that $5 million to take care of 50,000 people; this is a small amount. If I looked at just the governmental structure of the city of Cincinnati, we have 5,000 employees and we spend $15 million to take care of that 5,000 employees, and if I looked at the State government, and if I looked at the Federal Government, Lord knows of what the Federal Government is spending just on Federal employees. And, when we compare that to what the Federal Government is spending on the indigent, not even talking about the uninsured indigent, we will see that there are some wide variations. So, in America we are spending enough money that every man, woman, and child in this country could and should be receiving health care services.

The question is, do we have the resolve as a Congress and as a Nation to bite the bullet to develop the necessary programs and make the necessary changes in our system to assure health care services for all Americans? This is a national security problem, and I hope that we will approach it with the same aggressiveness that

we approach that issue. So, we cannot just look at it as a problem of uninsured indigent. There is, as we all know, a maldistribution of resources, and what I just recounted to you with the city of Cincinnati spending $15 million on 5,000 employees, versus $5 million on 50,000 uninsured indigents, is a maldistribution. We could look at the corporate community, and we could see the same kind of thing.

So, we've got to begin to address the issue of how are we going to redistribute the resources. As a physician, I am opposed to this problem being put on the backs of the physicians. We are the gatekeepers. We provide a valuable service, but we are not the cause of the problem, and we can look to other national health care systems for potential solutions. The Canadian system has been talked about. Yes, there are pros and cons, but we can look at, and need to look at, some means of redistributing the resources so that all of these billions of dollars that we are spending can be put to more effective use. I asked Ms. Olman about the $88 million in uncompensated health care services being provided by the hospital council in Cincinnati, I want to know who received it, and what was the impact on their health status?

And, you can ask that in every city across this country where the hospital systems, or whatever systems, are giving away millions, or not receiving millions of dollars in compensation for care that they are providing.

The next issue is access to health services. There are lots of studies in HCFA on access. This country, in the late 1960's, embarked upon the whole issue around neighborhood health centers, community-based services, be they partnerships between private doctors and/or government-sponsored neighborhood health centers; they worked.

And, there's enough data on the books to show. We did a preliminary study here in Hamilton County to look at those patients who received services in our neighborhood health centers, how do they compare with hospitalizations of those patients who received no care in our clinic system.

What we found on a preliminary basis was that our patients require 15 to 20 percent fewer days in the hospital and fewer resources. That was because we did more preventive care, more continuity of care, more health maintenance kind of activities.

And, guess what happens at the Federal Government level, as well as the State and local government? When the funds become short, and everyone wants to talk about the budget deficits, these kinds of preventive services are the ones that get cut first. But, if you look at what the Government is spending on primary care for the poor versus what they are spending on health care costs for Government employees, it will surprise you.

Finally, yes, we can solve the problem, and, yes, I can tell you how to solve the problem. We do spend enough money on health care where every man, woman, and child should be able to receive health care, unfortunately it is maldistributed in the wrong directions. We are paying for some of the wrong things.

But, we must have a resolve as a Congress, as a citizenry, to be willing to make the change. The system needs an overhaul. We know that if we had a 1955 automobile, and unless we were going

to keep it as an antique, we would not be spending thousands and thousands of dollars trying to rebuild individual components of that car just to make it functional and work. But, we are taking the same approach to trying to fix the health care system.

We need a major overhaul, not a piecemeal tinkering with various parts of it, and I hope that this Commission will take that approach, be brave, be bold, and come forth with a program that does not necessarily penalize any particular group of providers, but can provide access, can provide care to our citizens, to those who are going to be responsible for manning our armies, for manning the middle levels of our corporate communities.

Thank you.

STATEMENT OF DR. JUDY DANIELS, DIRECTOR, CINCINNATI HEALTH SERVICES NETWORK

Dr. DANIELS. I feel like I should start by saying amen.

I'm Dr. Judy Daniels. I'm speaking to you today wearing two hats, reflective of my experience in the medical community in Cincinnati. I practiced emergency medicine in various hospitals since 1971, and after seeing the large number of patients coming into these emergency rooms through the years, seeking and receiving episodic crisis-oriented care that should best be delivered in community health centers and in doctors' offices, I redirected my efforts into the public sector.

I received a master's in public health a few years ago, and since 1987 I've been medical director of the Cincinnati Health Network, which receives Federal grant funds from the various programs at the Federal level and distributes those locally to six community health centers, a prenatal project attempting to address infant mortality, and a homeless health care project, and would like to make just a quick aside to thank Mr. Gradison for his efforts in our behalf in securing those grant funds.

I decided I would share with you a couple of personal experiences of the past week, one which illustrates my concern about emergency medicine and what is happening there, and the other concerning public health and preventive medicine and what I see as problems there.

Certainly, this brave young woman who spoke to you about her pregnancy and the problems in obtaining prenatal care has said far better than I what really are the issues. I did, however, have the occasion to attend a woman in labor within this past week in an emergency department. When I called the obstetrician, the first question was: "Does she have insurance?" The answer was no. I was told she could not be cared for. This young woman was placed in an ambulance and sent to the University Hospital to complete her labor and deliver her baby.

So, the problem with access exists in our community. This isn't to indict any one hospital or any one doctor. It is to simply address the problem that exists here within our own area.

The other thing I wish to share with you is even more personal, but this week I celebrated the sixth anniversary of my own successful surgery for breast cancer. My life was literally saved by a mammogram when I was very young. I was, therefore, moved when I

read in the New York Times within the same period, "Guide on Mammograms," and how they are to be used to detect early breast cancer, the efficacy and the ability to save women's lives. And then, to read further in the article where, even though this has been shown to be effective, and in my own personal case I'm grateful, only 15 percent of the women in our country receive those on the basis on which they are recommended.

So, as I ponder both the issues from the emergency department perspective and the issues of preventive and public health, I start to look for a solution in my own thinking. I don't claim to be wiser than the other people in this room. I have maybe a little bit unique experience, we each do, we each bring to it that perspective.

When I was asked to speak, a friend of mine provided me with a book I've grown to love. It's the National Health Insurance Hearings Before the Committee on Finance, U.S. Senate, 1971, so I realize that many of the things I thought I was very smart to figure out and share with you actually have been done for a very long time.

And, I guess the biggest difference I could tell as I pondered this and read through the proceedings of that long ago is that, whereas the question was being asked in 1971, is health care a right, or is health care a privilege, I am happy to report that now all concerned do agree that it is a right of citizenship, and it is to be provided. This includes, of course, the AMA, things like the Washington Business Coalition, industry, Physician for National Health Plan, even the Heritage Foundation recently has maintained that same position.

So, I guess that the remaining question for us, and I do agree with Stanley, that we do spend enough on health care in this country, and it is basically an issue of maldistribution. I guess we need to look at the various options open to us in order to address the dilemma.

Some people have advocated expanding Medicaid for poor people, noting that it only covers at present somewhere around half of the people who could be eligible. Other people, of course, have spoken today, and many people favor expanding business input. I would prefer to see an overall approach taken where, with some partnership, including both business, industry, private/public sectors, that we come up with a universal health insurance plan that is available to every citizen, does allow every citizen to receive care in their community, at the same level of quality as any other citizen.

Thank you very much.

Chairman GRADISON. Thank you, doctor.

Steve?

STATEMENT OF STEPHEN D. WILHIDE, PRESIDENT AND CHIEF EXECUTIVE OFFICER, SOUTHERN OHIO HEALTH SERVICES NETWORK

Mr. WILHIDE. Congressman Gradison, Mr. Balog, Dr. Davis, honored guests, my name is Steve Wilhide. I am president and chief executive officer of Southern Ohio Health Services Network. I've served in this capacity since the network was established in 1976. A private, not-for-profit corporation, the mission of the network is

to assure accessibility to quality comprehensive primary health care services for all residents of Adams, Brown, Clermont, and Highland Counties. All four of these rural counties, located east of Cincinnati along the Ohio River, are designated part of Appalachia. They are also designated, in part, or in whole, as medically underserved areas of Federal designation, and health manpower shortage areas due to the lack of physicians in those areas.

The network itself employs 28 physicians with specialties—family practice, internal medicine, pediatrics, psychiatry, and obstetrics and gynecology, and I might add that Mrs. Rigg finally did find us in her sixth month, I'm thrilled that she did find us. I apologize for the fact that she did not find us until her sixth month, and I'd like to explain why.

Our funds are very, very limited. Our Federal funds constitute about 30 percent of our budget. Our funding has not kept up with inflation, and we, unfortunately, do not advertise our services because most of our practices are closed to new patients. We just don't have the capacity to take on a lot of new patients, so those that are fortunate enough to find our services get the care, and Mrs. Rigg was referred to us by an emergency room physician. She is under care, and her 17-month-old son now will be seen by our family physicians at the same locality.

We have specialties in family practice, internal medicine, pediatrics, and psychiatry in 12 small communities in these four counties.

As I said, approximately one-third of our funding comes from the Community Health Center Program, a program that Dr. Daniels and Dr. Broadnax also are affiliated with in Cincinnati. Other private grants and donations also help support our mission.

The network also operates prenatal programs and a WIC [Women, Infants, and Children], nutrition program in Adams and Brown Counties. Over 150,000 patient visits were provided this past year by network professionals and physicians.

While our service area is very poor, with Adams County having the dubious distinction of being the poorest county in the State of Ohio, 38 percent poverty, lack of access to health care is not solely due to economic barrier and lack of health insurance. Certainly, that's a problem, but physicians are reluctant to go to rural isolated areas for professional and personal reasons. A recent study by the physician recruitment firm of Jackson & Coker, determining physician reasons for choosing practice locations, gave the available hospital facilities as the most important consideration.

Now, I give you that a 60-bed hospital does not have all the high technology one can find in the city, and, therefore, physicians feel they are deprived of many of the tools they need to practice their profession.

Of 20 possible factors in considering a practice location, high medical need ranked last. Also significant to note is that nearly 57 percent of the physicians sampled indicated a preference for a suburban location. Less than 14 percent preferred a rural location.

Communities with less than 25,000 population, which constitutes the entire population of Adams County, were preferred by only 8 percent of the physicians surveyed.

Of the 28 physicians practicing with the network, 20 were recruited through the National Health Service Corps, as a result of

having had medical school scholarships from the Public Health Service of the Federal Government. This program has been eliminated.

While the network has been forced to hire a full-time physician recruiter, we have been unable to find physicians for vacancies. In a small town 35 miles from Cincinnati in part of Congressman Gradison's district, the community may lose its only pediatrician who works for us because we've been unable to find him a partner for the past 2 years.

We are currently attempting to recruit 12 primary care physicians to fill vacancies in our four counties.

The network provides the only obstetrical service in all of Adams and Brown Counties, and employs the only pediatrician, and there's only one for two counties, and the only psychiatrist in these counties. Two of the three obstetricians were recruited through the National Health Service Corps, again, a program that's no longer available to us as a resource. The only psychiatrist is fulfilling a National Health Service Corps obligation, and I wish you could hear her talk about her caseload and the waiting lists that people have to be on to see her. And, by the way, her youngest patient was 2 years old. The sole full-time pediatrician was recruited as a National Health Service Corps obligated physician and has remained with the network in Brown County for the past 10 years.

In 1976, when the network was founded, there were the same number of physicians practicing in Adams and Brown Counties as presently. This is in spite of the fact that the network currently employs nine physicians in Brown County and five in Adams County. That's the majority of the primary care physicians practicing in those two counties.

The counties are still experiencing a shortage, and the situation is projected to worsen due to the impending retirement of several physicians. The prospect for replacing National Health Service Corps obligated physicians in these counties, when their obligation is completed, is grim, particularly in Adams County. Adams County Hospital is one of the largest employers in the county, and should we not be able to replace the physicians it would be threatened with closure.

In addition to having an inadequate supply of physicians, the area has a much higher than average incidence of chronic disease and infant mortality that is so common in a poverty environment. Mortality, heart disease, cancer, cerebral vascular disease, and chronic obstructive pulmonary disease is higher than the average for the State of Ohio.

Three of our four counties rank in the top 15 percent of counties in Ohio having the highest teenage pregnancy rate, and I have to add as a personal note, one of the most difficult decisions in my career was that of having to shut down an adolescent health program in 1978 because the Federal Government decided that such programs were politically unacceptable and that teenagers getting birth control, sometimes without parental permission, was unacceptable. And, as a result, we now have the highest teenage pregnancy rate in the State in that county.

Brown and Adams Counties also have more low birth-weight babies born than the average for the State of Ohio.

Three of the counties of the four have a higher percentage of elderly than the State of Ohio. All of our physicians provide nursing home medical care services. Otherwise, perhaps, the nursing homes would be forced to close.

Resources to address these problems are grossly inadequate. The network employs nutritionists and offers health education classes to address these problems, but our resources are far too limited to address the need.

County health department budgets are even more limited, and I might add, this was mentioned earlier, when the money gets tight, the first programs to go are those that we can receive no reimbursement for, and, perhaps, which do the most good, like Community Health Education Programs, Nutrition Services, Health Promotion Services, and the Adolescent Health Program, which was eliminated for example.

In conclusion, while it's certainly true that lack of health insurance, including ineligibility for Medicaid or other payment sources, is a major barrier to receiving health care in our area, the lack of health care providers, particularly primary care physicians, poses an equally serious problem.

Furthermore, the lack of resources for health education and disease prevention results in a significantly higher demand for medical care. Programs such as the National Health Service Corps are critical, and should be restored if people in isolated rural areas and inner cities are to be assured of access to health care.

Thank you very much.

Chairman GRADISON. Thank you very much.

Jim?

Commissioner BALOG. So much to ask. Dr. Broadnax, when you were making your remarks, a couple of times you talked about, "let's get on with it, let's bite the bullet and do it." What is "it"?

Dr. BROADNAX. It is, and, in fact, Dr. Daniels sort of reemphasized it for me, there were hearings in 1971, we know the solutions.

Commissioner BALOG. What is "it"?

Dr. BROADNAX. What is "it"?

Commissioner BALOG. Yes.

Dr. BROADNAX. Well, there's a system of solutions; it's not just one system, but a system of solutions. One would consist of universal health insurance, or—which is a concept similar to what the Canadians have, that provides a health insurance for all citizens. It redistributes the resources so that everyone is guaranteed access.

Now, we do know, and the Canadian system has been studied enough, where we know where the problems are, and we know what not to reproduce. So, we can design a similar system, call it our own, universal health, with various components. We have to address long-term care, as well as acute care, but emphasizing prevention, early intervention, and to not make the same mistakes. So that, it is a universal-type system comparable to or similar to the Canadian system, where we know from research that they are spending less per capita than the United States, their life expectancy is longer than the United States, their infant mortality rate is lower than the United States.

So, while we sit back and debate and continue to research, the problem will continue. As I've indicated, HCFA has funded millions

of dollars in pilot programs. I can go through the HCFA compendium and come up with a number of components to put "it" together, but "it" would be a program that would offer some universal health insurance plan that would also provide prevention, early intervention, as well as curative services, and home care.

Commissioner BALOG. Well, the Canadian system has, as you mentioned, certain pitfalls, certain things we shouldn't do, and I notice that Dr. Daniels is wearing two buttons, one that says, "Health Care For All Now," and the other one says, "Long-Term Care." The Canadian system doesn't provide those two things, it doesn't provide long-term care.

Would you suggest that we wait for "it," that is the central theme of universal coverage, and wait for long-term care later and follow the Canadian model that way, because, again, they have resource problems, and, as you know, they have allocation problems. They solve their problems by capping total expenditures in each Province, and they solve their problem by queing. They simply don't provide all the technology in every area. You've got to fly in an airplane to get to a CAT scan in Canada from many places.

So, there are problems. There are differences, and there are things which we would have to give up. For example, malpractice coverage. Malpractice cases in Canada are far less frequent than they are in America, and one of the reasons is that if the hospital or the doctor is found to be innocent, the plaintiff pays for the whole case, the whole trial, you see. So, there are a lot of things you have to change, you are absolutely right. I have been at this a long time, a number of years, and a number of commissions, and when I hear these individual cases, as we heard in the last panel, of individuals dropping between the cracks, it's pitiful. It really hurts. There are no questions you can ask. You can only say, why is that so, and how could you have a systemic overhaul of this system in order to do it.

So, you are absolutely right. The data exists, the courage to do it is the problem. If we could start from scratch, you and I could probably do this with this audience in the afternoon, but we aren't starting from scratch.

Dr. BROADNAX. Well, let me just address that component. What you are getting into is that implementation mode.

Yes, we can come up with the model that we could implement. Now, we would have to implement that in phases, and it would be like building—trying to build a new hospital when there's a current hospital on the grounds. We tear down one part, build there, tear down another part, then rebuild there, while we shift patients around. So, we are going to have to do that.

So, yes, there are some parts of the universal plan that we can implement. We would have to implement the long-term care phase in phases. So, we should be realistic that we can't do the overhaul all at once, it would have to be in phases. The system did not get in the crisis that it's in overnight, and we should not expect to solve it overnight, but we have to have a road map.

And, as my grandmother used to say: "If you don't know where you are going, any road will get you there." Right now, we are trying to go somewhere, and I'm hoping that this Commission will be strong enough and brave enough to develop a road map; and

that Congress will have the will to make dramatic changes so that we're not sitting 17 years from now reading these proceedings and asking ourselves, whatever happened to the Pepper Commission's report of 1989, and Dr. Daniels and I will be here in our wheelchairs 20 years from now saying, well, we have a copy of it, and you will ask us, well, whatever happened to it.

Commissioner BALOG. Partly we are talking about nomenclatures. I think that our system, what we have now, is "medicure" system, we do not have a Medicare system.

Dr. BROADNAX. Right.

Commissioner BALOG. Our system was designed for good and sufficient reason, proposed by President Truman in 1949, I think, we got it passed in 1965 something like that, it was a "medicure" system. It was based upon acute care in a hospital, and we are trying to build the rest of the system around that "medicure" facility. We heard today talk about subacute, how to take some of the surplus beds and devote them to other kinds of uses. Now we are talking about long-term care, which is really quite different than the "medicure" system we have.

How do we graft this all together? How do you get this? And, part of the problem, is that you don't have a seamless system. You have people stuck in one part of the system at too high a cost; you have them stuck in another place without availability of what's needed for proper care. It's a very, very serious problem, and we'll have studies like that piling up for quite a while, I think.

Dr. BROADNAX. Let me just make one more comment. We're seeing more and more representatives from the business community now beginning to endorse systems similar to the Canadian system, if we look at it from the economic bottomline, where will this country be economically in 20 years, and can we afford not to do anything, I think industry has said, we must do something. We, the private sector, cannot do it alone. It must be, as Dr. Daniels stated, a joint public/private partnership, willing to do a major overhaul.

So, our economic destinies will depend upon what we do in 1989, and what you all launch can be critical. It's significant that the business community has now seen that the light at the end of the tunnel may be a train coming from Japan or Germany.

Commissioner BALOG. That's right, absolutely right.

Dr. BROADNAX. So, we have got to do something, and you all are in an excellent position, because people are trying, people are ready for compromise, people are ready for change.

Commissioner BALOG. I think we have to let Dr. Davis talk now.

Commissioner DAVIS. I really wanted to elaborate on what you've started, and I would agree that this is not the forum to debate the Canadian system, but Mr. Balog is exactly right, it has many, many fallacies. It may be improved in Canada, it would not work in this country.

I would like to expand on also the fact that Dr. Broadnax said physicians are not the cause of this problem, and while I have two colleagues here, I would like to hope that both Dr. Broadnax and Dr. Daniels, I hope that every physician in Ohio, in fact, I hope every individual in Ohio, knows what's going on in Congress at the moment, all day and throughout all our hearings we keep hearing

about Dr. Daniels' button, "Health Care for All Now," and that's what we are trying to move toward.

Let me remind you, though, that currently in Congress, under the Bush administration's pressure, there is a movement to ration health care in this country, and it's being called a euphemistic name called expenditure targets [ET], which will inevitably lead to rationing of health care in this country, exactly the opposite of all the testimony we have heard today.

Unfortunately, there will be no public hearings on this issue. It's being done in closed session in budget reconciliation, where in closed session those conferees from the Senate and the House can, in a very easy, and a very quick, and a very dirty way, ration health care in this country.

And so, the physicians of this country, and I hope we have your total support in Ohio, are working very hard to stop this movement to rationing health care in this country. We really cannot afford to do that.

And, more importantly, Dr. Broadnax and Dr. Daniels, I don't want you, or me, or any other physician to be put in the position by the Congress of this country of rationing health care ourselves, because if you put a cap on expenditures, and you say to the medical profession, now you continue to provide the same quality of care to an ever increasing number of people, more and more elderly people, and the elderly-elderly, over 65 and 85, with new technology that's coming down the line, our product is getting better every day, we want you to continue to supply all this to all of the American people. And, they are saying to us as physicians, you are going to have to ration care, and we cannot afford to do that, and I would hope that you would let Mr. Gradison and your other Representatives in Congress know that this country cannot afford to ration health care at this time.

Chairman GRADISON. I would like to comment on this. I didn't intend to bring it up myself, and it is not an issue before this Commission, but why beat around the bush? The American Medical Association has embarked upon a policy of trying to scare the elderly of America into believing they will not get health care because we've only provided for a 10-percent increase in the amount that will be paid for hospital bills next year. These are scare tactics. These are misrepresentation. There is no rationing involved.

If there's any rationing, it's just that the rate of increase and payments to the doctors won't be as much as the doctors would like.

Now, the Bush administration is backing this expenditure target proposal. It was not dreamed up behind closed doors. We had extensive public hearings. We heard from many, including the American Medical Association, and in the end didn't happen to agree with them, but that's what the process is like. I certainly respect their ability, their right to campaign against this, and to wear these ET buttons, but I think it would be a sorry day for the elderly of America if ET goes home.

Now, I want to——

Commissioner DAVIS. Mr. Gradison, then I interpret your comments as saying to your constituents here that you favor expenditure targets which will inevitably lead to rationing of health care

in this country. You are ready today, as an elected official, to ration health care in this country?

Chairman GRADISON. The answer, of course, is no. I explained the expenditure targets as a means of slowing down the out-of-control growth of payments for physician services under Medicare. I would like to get back to the subject of the hearing and ask a few questions of Dr. Broadnax.

The Canadian system has as one of its characteristics that it is not uniform across the country, it varies Province by Province. The Federal Government in Canada makes certain funds available, and then it's up to the States what kind of plan to have, whether to have a plan. Would that be acceptable to you in broad principle? I have two or three questions, I'm just drawing you out on what you like about the Canadian plan.

When you say "universal," does the plan have to be identical in every State, or could we follow the Canadian plan and leave it up to the States here as they have to the provinces?

Dr. BROADNAX. I would say that it would need to have some basic fundamental provisions, and that where States wanted to build up more than that, they could, but a basic universal plan would be uniform across all States, and they could build up higher than that.

Chairman GRADISON. With a State administration? They have Provincial administration, they do not have national administration of the plan. Would it be acceptable to you if we had a plan, if it were administered by the States, rather than by the National Government? Medicare is national, it's uniform. Medicaid is not. The Canadian system is administered by the Provinces.

Dr. BROADNAX. Again, I think there would need to be—I think there would need to be national guidance and guidelines. I would not like to see it necessarily turned over to the States, because all we need to do is to look at what happened to Medicaid, in terms of what different States did with it.

And, we all know that in some States it's woefully a problem, and in others it's very good. So, I would like to see a major national presence with State and private input, because I see this program as being contributed to by, not only public resources, but by private resources.

Chairman GRADISON. Well, now let me come to that. In Canada, they've outlawed private health insurance, to the extent that a company may not offer private health insurance that competes with any benefit provided under a Provincial plan. Are you for outlawing private health insurance that would compete in offering benefits in this country? I mean, most of our system is built on private health insurance, and that's a rather important issue. Would you go the Canadian route?

Dr. BROADNAX. I think that is a question, as I indicated earlier, there are a number of problems with the Canadian system that we would not want to duplicate.

Chairman GRADISON. Yes.

Dr. BROADNAX. That is one of the issues that I think we would have to look at to see whether or not—and, I think we would need to do some sort of compromise between public and some private offerings that are possible.

But, give me enough time, and I'll come back to you.

Chairman GRADISON. No, I welcome it. These aren't loaded, I'm just trying to think the thing through.

Dr. BROADNAX. Yes, that's good.

Chairman GRADISON. I've got one other thing, you mentioned putting it in phase by phase, which certainly makes sense, and I really think that in the end this Commission will have done well if we recommend a structure, perhaps, with some phasing in of elements.

If we were to do this, "it," as Mr. Balog calls it, and if you had to make a choice between which would come first, long-term care or the hospital preventive care or acute package, which one would you do first, or would you do them both at the same time?

Dr. BROADNAX. You actually gave——

Chairman GRADISON. Well, I'm not trying to pin you down, you know, I want to give you some choice. I just want to get a sense of how you'd phase this in, in broad terms.

Dr. BROADNAX. I would phase in the acute and preventive early intervention phases first, because what we can do is to minimize long-term care if we provide services to assist our seniors and elderly seasoned citizens into living independently.

So, if we begin our focus on how we can assist people in living independently, providing support, not requiring that their families spend down in order for them to stay at home and receive some assistance, that, I think, is where we should start, not necessarily with long-term care, although that's a big piece, but we can impact long-term care and the need for it by starting with early intervention, prevention, trying to assist people in living independently, and assisting their families in them living independently.

Chairman GRADISON. Thank you. That's very helpful. I really appreciate it.

Any other questions?

Commissioner DAVIS. No, sir.

Chairman GRADISON. Thank you very much to the panelists.

And, now for our final panel, Solomon Marble, the president of the Ohio chapter of the American Federation of State, County, and Municipal Employee Retirees; Judith Green, a board member of the Cincinnati Area Senior Services; Ken Daily, from the Greene County Council on Aging; and Gene Elkus, a board member of the Cincinnati chapter of the National Multiple Sclerosis Society.

Mr. Marble, would you begin, please?

STATEMENT OF SOLOMON MARBLE, PRESIDENT, OHIO CHAPTER, AMERICAN FEDERATION OF STATE, COUNTY, AND MUNICIPAL EMPLOYEE RETIREES

Mr. MARBLE. Good afternoon, Congressman Gradison. My name is Solomon Marble, and I'm a retired city of Cincinnati employee. I am here today as president of Ohio's statewide retirees chapter 1184 of the American Federation of State, County, and Municipal Employees, known as AFSCME. AFSCME Retiree Program has chapters all around the country. Our membership is over 120,000 people strong, all retired public employees like myself.

AFSCME members, both working and retired, are all deeply concerned about the enormous costs of long-term care for chronic illness. In fact, when AFSCME recently polled its 1.2 million working members, the issue that was most important to them personally was finding a solution to the crisis of long-term care. That's why we are looking to you, Congressman, and to the other members of this Commission, to solve this growing national problem.

Just 2 weeks ago, I attended the annual meeting of the AFSCME Retirees Council, where delegates unanimously approved a resolution calling for a Federal program to cover long-term care. Many of our members have personal experiences with spouses or parents with chronic illness. We have many others who are retired health care occupations, such as nurses, technicians, nurses aides. These people come to understand the stress involved with providing care for loved ones, the tremendous strain it puts on the family's pocketbook.

With typical nursing home costs of $25,000 a year, and home care costs not far behind, it is easy to see how savings of a lifetime can disappear overnight.

I am well aware that some people take issue with our points of view. They say the answer is not another Government program. They say that the private insurance companies should solve the problem of long-term care, but this solution makes very little sense to me. To insure people as cheaply as possible, you need to have age groups sharing the risk, and a whole lot of people into an insurance plan. How do you do it when you have dozens of insurance companies vying for their share of the population, and how do you convince 30-year-old's to buy insurance for long-term care when they associate the need with the oldest and the most sickly members of society. At 30, I'm not so sure that I even would buy insurance on long-term care myself

More people could be covered for long-term care if employers started offering it to the employees, in the same way they now offer coverage of acute care. But, today's rapidly rising health care premiums make it highly unlikely that employers will want to take on this additional burden. The few that have shown interest in long-term care insurance are offering it to the employees and retirees at their own expense, and this brings us back to the problem of trying to convince young people to pay $75 to $100 a month or more to cover themselves for long-term care.

The fact is, if old people are the only ones buying insurance for long-term care, then the price will always be high. Average seniors with an average income and savings will be permanently locked out, but the problems associated with private coverage don't stop with cost.

With most plans available today, you don't get much for your money. One of the biggest shortcomings is that most plans don't account for inflation when they are figuring benefits coverage. If a 60-year-old were to buy insurance today that provided flat $80 a day in coverage, what good will the policy be in 25 years, when the beneficiary is 85 and nursing home costs average $300 a day? Without a cost of living clause, most of these plans are poor investments for anyone but the very old.

Also, insurance policies often exclude coverage for the very illnesses that are most common in nursing homes, particularly, Alzheimer's disease. They also commonly deny benefits to anyone who has not been hospitalized before being admitted to the nursing home. That exclusion alone would effectively eliminate over 60 percent of the nursing home patients who enter these facilities directly from their own home.

Last year, when the Consumers Union started 53 different long-term care policies, it took note of these and other drawbacks before making its recommendation in Consumer Report magazine. Ultimately, it determined that every single plan had serious limitations, and could not be heartily recommended to the average American. The Consumers Union agreed with AFSCME that private insurers cannot possibly provide the answers to the Nation's crisis in long-term care.

The Federal Government, on the other hand, has the ability to spread its risks over millions of working and retired Americans, and to pool the resources of these Americans in order to keep costs down for everyone. We feel that a successful national program to cover long-term care must follow social insurance models, based on the concept of shared responsibility.

Long-term care is an issue that doesn't affect the elderly alone, as clearly shown in AFSCME's survey of its working members. Any family can certainly find itself in need. They may have a child with a serious condition like cerebral palsy, or a breadwinner who is significantly disabled in an automobile accident. Even when their relatives are in need of care as elderly, the entire family feels the effect.

Clearly, every family is a risk, and every family needs to be part of the solution. The solution we envision would be a national insurance program administered by the Federal Government, that would cover Americans, all ages, for long-term care in nursing homes and in their homes. There would be no mean-test for coverage. So, Americans would not have to impoverish themselves as they do under Medicaid.

Quality of care should be a top priority of these programs. AFSCME is especially sensitive to this issue, since the union represents thousands of workers who provide the long-term care services. This is an industry built on low wages, unskilled, untrained workers. If America wants their relatives to get the best care possible, conditions for these workers will have to change. Solutions to this problem must be part of our national solution to the crisis in long-term care.

In closing, I wish to express my thanks to you, Congressman Gradison, and to other members of your Commission for inviting me to testify here today. I hope the hearings sponsored by the Commission result in passage of a Federal program for long-term care. Certainly, that great man, Claude Pepper, would have loved to have seen that day.

Thank you.

Ms. GREEN. Representative Gradison and members of the committee, you will be pleased to hear that I'm not going to read this, but I am going to present it to the committee.

Chairman GRADISON. Thank you.

STATEMENT OF JUDITH B. GREEN, FOUNDER AND EXECUTIVE DIRECTOR OF PRO SENIORS AND BOARD MEMBER, CINCINATTI SENIOR SERVICES, ON BEHALF OF THE OHIO LONG-TERM CARE ACTION NETWORK

Ms. GREEN. My name is Judy Green. I was the founder and executive director of Pro Seniors, a Cincinnati legal advocacy group, which often deals with long-term care issues, and currently I serve on the board of Cincinnati Senior Services.

Today, I am speaking for the Ohio Long-Term Care Action Network, a coalition of 23 statewide and regional organizations working for real solutions to our long-term care crisis. The network includes such major statewide organizations as the Ohio State Council of Senior Citizens, AARP, the National Association of Retired Federal Employees, the Ohio AFL–CIO, AFSCME Council No. 8, Ohio Education Association, Ohio Council of Churches, Catholic Conference of Ohio, Citizen Action, Alzheimer's Association, Ohio Easter Seal, United Cerebral Palsy, and the American Council for the Blind, the National Association of Social Workers and the Ohio Nurses Association.

The network works closely with the Long-Term Care Campaign, a coalition of more than 130 organizations on the national level, and works here locally with the Cincinnati Long-Term Care Network.

Even with all this, the organization is just beginning. It was Congressman Claude Pepper who really provided the impetus to bring us all together. He showed the enlightened congressional action on long-term care was at least within the realm of the possible. Though this bill was defeated, and it only partially addressed the problem, it ignited enormous grassroots support for a solution.

Why? Simply because the problem has become so widespread, because it can be so devastating to families, and because all the Band-Aid solutions have clearly failed.

The defeat of Claude Pepper's bill also brought about the Pepper Commission, with the charge to recommend a national policy on long-term care.

Well, here today, Claude Pepper's grassroots campaign meets Claude Pepper's Commission. We both have our jobs to do, let's not let him down.

The Ohio network has adopted the 10 legislative principles of the National Long-Term Care Campaign. We feel strongly that they set forth the necessary dimensions for a serious and comprehensive solution to the problem.

I have included a list of these principles in detail in my written testimony, but they boil down to this. We need a comprehensive long-term care program that is based on social insurance principles, similar to Social Security and Medicare. This program should be available to all who need it, regardless of age or income. The program should provide a comprehensive range of facility, community-based, and home care services.

The program must spread the financial risk as broadly as possible through a universally financed system.

This Commission will come under enormous pressure, yet again, to provide only a Band-Aid approach to the problem. Many politi-

cians have said, and will continue to say, that a comprehensive program is too costly, and that increased taxes or premiums are politically unpopular. But, the national poll done last November by Peter Hart shows that 65 percent of Americans, in fact, are willing to see increased taxes to support such a program.

The experience with the Catastrophic Health Care Act makes it clear that the way forward does not include repeating the mistake of putting the cost burden on too narrow a segment of potential recipients. Of course, we are all potential recipients of long-term care, and a long-term care program addresses families, as much as it addresses those directly needing the care.

Families know quite clearly that long-term care is expensive now. The choice is not whether or not to pay for it, but to pay for it rationally and humanely or irrationally and inhumanely. We pay by the lottery of chance now. When someone in your family needs long-term care, both the patient and the caregiver often lose assets, and the caregiver often has to sacrifice a job, and much of his or her freedom, to provide the care. This crazy lottery of family disaster has no place in modern America. We can't afford not to have social insurance for long-term care.

There will be pressures to confine the benefits to the elderly or the poor, but the need for long-term care does not begin automatically at 65. We had evidence of that today. In fact, there are almost twice as many nonelderly adults who need long-term care as there are elderly, and there are an additional 2.3 million children, for the nonelderly the need is no less and is often for a longer period.

As for confining benefits to the poor, the only real long-term care program we have, Medicaid, already does that. The problem, of course, is that far too many are reduced to poverty in the process of paying for care. This safety net, inches from the ground, is not the security that American families want and deserve.

Finally, there will be those who say that the insurance industry will solve the problem of private long-term care policies. My colleague has just pointed out in his testimony how wrong that is. In the Rivlin and Wiener study cases by Brookings Institute, and a latter computer simulation was done of five types of policies, the study concluded, and I quote: "Under the policies simulated by 2016 to 2020, private long-term care insurance would account for between 7 and 18 percent of total nursing home expenditures."

In short, most people cannot afford these policies now, and are not likely to be able to in the future. Private long-term care insurance is a solution only for the well off, who are least in need of a solution. It cannot be an excuse to delay or compromise a comprehensive Federal program.

Representative Gradison, I have with me a number of statements that support comprehensive long-term care legislation, brought by the representative of the Dayton Long-Term Care Coalition. I would urge you to enter them into the record of this hearing.

Also, I would urge those members of the audience that support this kind of comprehensive long-term care social insurance we have outlined here today to stand at this time to show your support and wave your flag.

And, they've sat here since 9:30 a.m. I want to tell you all, thank you for staying here through all of this since 9:30 this morning.

We thank you for having this field hearing. We urge you to take back with you to Congress the clear message that it is time to bring about the realization of Claude Pepper's dream of long-term care security for American families.

Thank you very much.

[The information supplied for the record follows:]

THE LONG TERM CARE CAMPAIGN

LEGISLATIVE PRINCIPLES

American families are being stressed beyond their capacities because of the emotional and financial strains of providing long term care. A public program, which meets the following principles, is needed to address this family crisis:

1. Long term care services should be available to all who need them, regardless of age or income. Eligibility should be based on functional, cognitive or behavioral limitations, or the need for supervision because of risk to safety or health, or the need for support or training.

2. A national long term care program should provide a comprehensive range of facility-based and community-based health, social and support services. Services should be provided in such a way as to maintain and enhance personal independence in the community and in the setting preferred by beneficiary and family.

3. The financial risk for long term care should be spread as broadly as possible, through a social insurance program similar to Social Security or Medicare. The public program should provide a base of coverage for all.

4. The new public program should assist families and other informal caregivers. Families and friends should be an integral part of care coordination and should have access to supportive services and training to facilitate their caregiving. The program should ensure that the financial integrity and physical and emotional well-being of the family caregiver is maintained.

5. The new public program should be supported through sources of financing that are as progressive as possible.

6. Protection from out-of-pocket costs for low and moderate income persons should be provided.

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7. The program should ensure high quality and access to care for all. A strong, independent care coordination component should be a central feature of the program. Paid caregivers should be carefully screened and well-trained, with wages and benefits commensurate with the substantial demands and responsibilities of caregiving. The payment system to providers should be structured to ensure quality of care and cost containment.

8. Cost containment should be built into the program. The public costs of the program should be minimized while meeting consumers' needs.

9. The program should allow for phasing-in to ensure orderly development of the new system and all of its services.

10. The states should be encouraged to be innovative and flexible in administering and delivering long term care services. Research should be conducted on the adequacy of services to meet family long term care needs and on more accurate measures of disability.

Chairman GRADISON. Mr. Daily?

STATEMENT OF KENNETH DAILY, DIRECTOR, LONG-TERM CARE OMBUDSMEN PROGRAM, ON BEHALF OF GREENE COUNTY, OHIO COUNCIL ON AGING

Mr. DAILY. Congressman Gradison, distinguished committee members, I am Kenneth Daily, director of the Long-Term Care Ombudsmen Program, a program which is a nine-county program in west central Ohio. I am honored to offer this testimony today as a representative of the Greene County, Ohio Council on Aging. Our council consists of seniors and service professionals whose goals are to advocate and promote senior services in our county.

We began more than 10 years ago, and, currently, have over 50 individual group and organizational members.

Greene County is located in west central Ohio. Our county seat of Xenia, lies 18 miles east of Dayton. According to the 1980 census, Greene County has approximately 15,000 senior citizens.

At a glance, one might expect that we would face typical long-term care challenges. However, we are unique because the western half of our county consists primarily of rapidly growing urban areas, such as Beavercreek and Fairborn, while the eastern half, including towns such as Cedarville and Jamestown, remain very rural.

This situation poses difficult dilemmas when trying to link services with consumers. The availability of services is limited and fragmented.

In an effort to gain a better understanding of long-term care needs of our county, our council held a public hearing in March of this year. The testimony yielded some significant results. Among them we found the three most often mentioned needs were: inhome care and services, transportation, and respite services for caregivers.

First, in the area of inhome care and services, it can simply be stated, demand far outweighs supply. Naturally, the quality of life is a major concern for our senior citizens. Most prefer to remain in their own homes, or with family, as long as possible. This time at home allows for the least restrictive environment, the love of family and friends, and the continuity of life in familiar surroundings.

The need, however, of inhome care is much greater than services available. The largest provider of inhome services in Greene County had to resort to establishing acuity levels for clients or rationing of care. This led to limiting admissions, reducing frequency of care, waiting lists, and even dismissing clients who then must be placed in nursing homes.

The skyrocketing costs of institutional care, along with the limited availability of nursing home beds, increased quality assurance, and accountability mandates render inhome care and services a viable option. Frequently, inhome care can be provided at half the cost of institutional care. Inhome care, however, relies on case management, which is the integration and coordination of services and providers. When done efficiently, it will maximize both dollars

and services. This must be given a high priority when developing a national long-term care plan.

The other area of great concern is transportation. In Greene County, transportation is very limited. We do not enjoy the benefits of any public transportation system. We believe that counties which lack such systems should receive priority consideration for Federal funding. In many cases, the only transportation service available in Greene County is to local medical appointments and to congregate meal sites. But, even availability of these essential services is minimal.

All too often, the elderly person who needs out-of-county transportation simply falls through the cracks.

Finally, respite service for caregivers is a great concern to many in Greene County. Within the scope of inhome care, respite services are a critical support service, where the caregivers themselves can develop serious illnesses.

A 73-year-old gentleman related to us, has been providing care for more than 10 years to his 74-year-old wife who suffers from Parkinson's disease. He described how the stress of caregiving had resulted in a variety of emotional and physical problems which frequently impaired his ability to provide care.

Due to limited availability of affordable services, his wife just recently began to attend day care. He said that his need for reliable weekend and evening respite, however, had not been met.

This story is typical and certainly emphasizes the critical need for respite services as part of any home care program. Greene County has had an adult day care for 14 years, but there is still a need for respite services that day care cannot provide. Caregivers have a need for respite in the evenings and weekends. Respite is also needed for persons being cared for who are not eligible or cannot go to day care.

In the past several years, we have been developing these services, but we need support.

In closing, I would like to reflect on yesterday's celebration of the Nation's independence. I remind this honorable committee that when the settlers inhabited New England, we were blessed with a rare and precious gift, longevity. Our society was among the first in recorded history in which a person was likely to know his or her grandparents. We have come much further today, where now we can offer our senior citizens dignity, respect, and choices.

Thank you very much for your kind attention.

Chairman GRADISON. Thank you, Mr. Daily.

STATEMENT OF GENE ELKUS, CHAIRMAN, BOARD OF THE GENTRY SHOPS; MEMBER, BOARD OF DIRECTORS, NATIONAL MULTIPLE SCLEROSIS SOCIETY

Mr. ELKUS. Congressman Gradison, members of the Commission, and guests, my name is Gene Elkus. I am chairman of the board of the Gentry Shops, headquartered in Cincinnati, and I'm a member of the board of directors of the National Multiple Sclerosis Society, and I have with me Gail Price, who is a medical service associate at the National Multiple Sclerosis Society.

I deeply appreciate this opportunity to bring to the Commission's attention the problem faced by a unique population of individuals in this country for whom inadequate long-term care programs and the lack of comprehensive health care initiatives are not nightmares, but reality, a reality that has devastated and destroyed thousands of lives. I'm speaking of young people with physical disabilities, who out of necessity are forced to languish in nursing homes that are ill-equipped and unprepared to meet their needs.

There are approximately 250,000 persons with multiple sclerosis [MS] in the United States. Of these, about one-third may be classified as severely disabled. Because MS generally affects those in the 20- to 40-age category, it is the young adult beginning a career or family, or the mother of small children, who are typical nursing home residents with multiple sclerosis.

How do you explain to a 20-year-old that he is condemned to spend the next 30 or 40 years of his life in an institution where all the other patients are in their seventies and eighties?

As parents, how do you live with yourself knowing you have to place your son or daughter in a nursing home, because you can no longer physically provide for their care?

And, what do you tell the 5-year-old about why his mother has to live in that home with all the old people?

I am speaking as one who really knows what MS can do to a family. My wife has MS, and has had it for 20 years, and I've seen this beautiful, wonderful person progress into something less than what should have been. However, we are both grateful that we have the resources to provide for her care in our home, surrounded by the warmth of our family and friends.

But, for thousands of others with multiple sclerosis, there is no warmth, there's no home, family, or friends. In the prime of their lives, they are faced with the stark reality of living out their years in an institution designed to serve the elderly.

In a 1985 survey conducted by the National Center for Health Statistics, it was determined there were more than 81,000 people under the age of 55 living in long-term care facilities. Almost 45,000 of them were under the age of 45. With the development of new technology, the life expectancy of individuals with physical disabilities is constantly increasing, and the challenge of dealing with their special long-term care will continue to grow.

As nursing homes, and still are to a great extent, the predominant long-term care service, the time to develop a system for the appropriate delivery of comprehensive health care to current and future generations of young American adults is now.

The major issues are not what medical and social service programs constitute comprehensive long-term health care. Scores of professionals in these fields have developed, tested, and evaluated numerous options, and continue to design creative new initiatives.

The big questions rest in two distinct and inseparable areas: How to finance a system of long-term care, and how to overcome political obstacles along the way.

The Pepper Commission is a bright and valuable first step, and I urge its members to be committed to formulating constructive and meaningful recommendations to the Congress.

Additionally, it is imperative that you vigorously pursue strategies for integrating your findings into a system that recognizes and demands available, comprehensive, continual, assessful, and humane care for the young disabled adults of this Nation. Anything less than that, Congressman, is not acceptable.

I, again, express my thanks to the Commission for providing me the chance to participate in this hearing, and I'm honored to have been able to represent the quarter of a million Americans who, unfortunately, have multiple sclerosis.

Chairman GRADISON. I would like to thank you all. Certainly, Mr. Elkus, your comment about disability affecting all age groups is one that Claude Pepper stressed in our early meetings, and it's one that we will not forget.

I'd like to say a word about the role of insurance, because that was raised by Mr. Marble and Ms. Green. I think, this is my personal view, that it is as unrealistic to think that health insurance—that private long-term care insurance can solve the whole problem as it is to think that it has no role in solving the problem. And, I think what we are gradually starting to see is the growth of group plans of long-term care insurance, such as Procter & Gamble is offering, such as the Public Employees Retirement System of Ohio is offering, which are leading to the growing availability and affordable prices of group long-term care.

The Public Employees Retirement System has a plan which does not require physical exam, and at the age of 60 a $50 a day benefit costs $30 a month, a $100 a day benefit costs $60 a month, and I don't mean to trivialize $30 or $60, but I don't think those are beyond the range of many of the people who retire under those systems.

Regrettably, the Brookings study was flawed, in that it figured out the degree to which people could afford to buy long-term care insurance by using individual rates, rather than group rates. Well, you know, on that basis, Blue Cross/Blue Shield costs $5,000 or $6,000 a year, instead of $2,500. So, there are some conceptual problems.

I am not arguing private health insurance will solve the problem. I don't believe that at all. But, I also think it extremely unlikely, extremely unlikely in the end, that any Government plan in long-term care will be first-dollar with no deductibles and no coinsurance. And, indeed, every plan that's been introduced so far; for example, Senator Kennedy's plan, Senator Mitchell's plan, has very substantial—they do it in different ways—but very substantial deductibles in coinsurance in order to keep the costs of the program down. Senator Mitchell's plan; for example, provides no benefits during the first 2 years, and 30 percent copayment, that is a 70-percent benefit for nursing home and home health care after the first 2 years. Senator Kennedy's bill does it the other way around. It starts the benefits earlier, but then for the long-time patients, they then end up more on their own.

Those aren't the only ways to do it, but what that suggests is that the way in which the plan is designed, if there is a plan, will help to shape the private insurance, and we see that in Medicare, where the design of Medicare created a market and created a definition for what is the Medigap policy. It never covered everything,

it still doesn't, and it's not first-dollar. There are deductibles and there are copayments.

Under Medicare, and certainly the experience in working under Medicare, suggests at least to this member of the Commission that any additional benefits that are added are likely to continue to have something in the way of deductibles and copays, which still provides an incentive for private saving or private insurance, and still requires some safety net, whether it's Medicaid or some successor, for those who can't pay the deductible or can't pay—can't come up with the copayment.

I'd welcome your comments, but I wanted to try to express that, because we've had a lot of discussion of that within the Commission, and one of the witnesses that we met with in a private session a couple weeks ago, who I think is probably as strong a person for—I think Jim would agree with this—probably as strong a person as there is in this country for social insurance as a solution to national problems, is saying that he himself has moved to a point now where he believes that there is a role, not a total role, but a role for private insurance accompanied with a social insurance plan.

Mr. MARBLE. I agree with you to an extent. But, where have these private companies been all these years that they haven't come up with a long-term plan that a poor person can afford?

All I'm asking from the Commission is some type of legislation, I don't care whether it be private or a social, some type of legislation where when a person retires, regardless of how much money he made, he can die in dignity with security—I mean, have security and dignity, that's all I'm asking.

Too many people today who have retired have lost their dignity, they have no security. This is what we are asking for after we retire in our old age. Everybody can't work for Procter & Gamble.

Chairman GRADISON. That's certainly true, and the plans that we heard from at the outset were certainly not the typical plans.

I also have one question for Ms. Green. This is basically a philosophic problem. Why do you feel that there is any responsibility of Government to have a plan to provide for the wealthy?

Ms. GREEN. My experience at the Council on Aging was that making the programs available to all brought more people in of every economic strata, and my sense is that you've got to offer it to everybody to get everybody—to get all levels in. We're talking about basic fairness, I think.

Chairman GRADISON. Well, I mean, there are different ways to do this. Germany, for example, which has had a national health plan for generations, says to people, and I'm not saying this would work in this country but it's an interesting counterplay, because they are one of the countries people point to when they say we are the only country that doesn't have national health insurance, Germany is the one they point to that does.

If you have income over $40,000 a year, you are on your own. If you are under $40,000 a year, you are required to contribute something like 14 percent of payroll, 12 or 14 percent of payroll, and it's very expensive, as it would be here, into the national pool to pay the health care costs of the under $40,000 people.

Ms. GREEN. Yeah. Most people, I think, in this country that are over—well, let's take it a little higher, say $100,000 a year——

Chairman GRADISON. OK.

Ms. GREEN [continuing]. Are going to have their own insurance, because they want to go to their own doctors, they want to have more control over their health decisions.

Chairman GRADISON. Well, I don't understand the relationship of that to the question.

Ms. GREEN. So, they are going to be doing their own thing.

Chairman GRADISON. Yes.

Ms. GREEN. But, the system needs to be—and, take the person who makes $100,000 and has a catastrophic illness in his family, he's going to need it, or she, is going to need it.

Chairman GRADISON. Yes.

Ms. GREEN. I saw so many cases when I was with Pro Seniors of the kind of middle-class people who really thought they had it made, and then somebody went into a nursing home, and they spent down to get on——

Chairman GRADISON. Sure.

Ms. GREEN [continuing]. It was just—it was tragic, the stories you heard.

Chairman GRADISON. Of course.

Ms. GREEN. So, my sense is it has to be there. And, you know, we always ask for more than we think we are going to get, so that's in the neighborhood of negotiation. Don't you? Come on. Don't you ask for more than you think you can get?

Chairman GRADISON. Well now, let me answer that. I think it's a very good question. I think that to the extent that the pressure is for the, essentially, first-dollar comprehensive long-term care plans, which carry with them price tags in the order of $50 or $60 billion a year, it stops the conversation, the number is so high that there is a sense of, well, gosh folks, if that's what you want, we just can't do anything right now, and I've seen this happen.

George Mitchell, who is a self-defined liberal and certainly is no conservative when it comes to spending public bucks, has been severely criticized because he presented a plan with a 2-year exclusionary period, 2 years of no benefits, and then 30 percent copayment thereafter, which costs about $25 billion a year, and the elderly groups have jumped all over him saying, he's no friend of the elderly.

And so, it isn't a misguided or insensitive question on my part, or comment on my part, that sometimes the best is the enemy of the good. This may just be one of those cases.

I'm not saying don't stand up for what you believe, you should, you've got a responsibility to do it, but, I'll tell you right now, the Ways and Means Committee on which I serve is required, starting next Monday, to come up, not with $50 or $60 billion, but $5.3 billion of net increases in Federal revenues for the fiscal year beginning October 1 to meet a budget target, and we haven't the foggiest idea how we are going to do it.

Ms. GREEN. I guess when people are talking about what they want, what they see as the ideal, and somebody says, OK, how are you going to pay for it, we might very well say, well, how do you pay for $500 toilets for the Air Force, or how are you going to pay

for the S&L bailout. And, we know how many billions of dollars that's going to take. It all depends on where you are looking.

But, when it's older and sick people, it's somehow those are expendable in our economy, and I think that is outrageous.

Chairman GRADISON. I don't think that's a fair statement. The only group in this country for whom we have a national and very comprehensive plan, admittedly, focused on acute health care, is the elderly, and I'm glad we've got it there. And, there are a lot of gaps yet to be filled, but I think if you look at the society as a whole, it is simply not a fair statement that you made with regard to the old and the sick being neglected. They've been treated fairly, and there are gaps that need to be filled, but, believe me, there are a lot of nonelderly people paying into that payroll tax for Medicare that wish they just could pay for their hospital bills, like the two people who sat where you are now sitting who are paying into these funds but won't be entitled to any benefits until they are 65 years old. That is not a very fair system.

Ms. GREEN. No; it's not a fair system.

Chairman GRADISON. Now, I want to thank everybody for being here. As you know, we had scheduled this to end at 12:30 p.m., and I purposely have not tried to stick to that schedule, in order to give everybody an opportunity to appear. Those of you who have additional comments should submit them in writing, as I said at the outset. We will welcome them.

In conclusion, I want to thank my fellow Commissioners for being here, and I want to especially extend a word of thanks to the University of Cincinnati for making this excellent facility available for our meetings today.

Thank you, and the meeting is over.

[Whereupon, at 1:30 p.m., the hearing was adjourned.]

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